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Deliverable

D5.5 Project Methodology Guidelines

SOLACE-CEE

Solutions for Overcoming Homelessness through Integrated Care in the CEE region

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Abbreviations, acronyms and descriptions

Abbreviation - acronym used in document	Description
SOLACE-CEE /Project	Solutions for Overcoming Homelessness through Integrated Care in the CEE region
CEE	Central and Eastern Europe
PMG	Project Methodology Guidelines
PEH	People Experiencing Homelessness - ETHOS
IHSC	Integrated Health and Social Care - A coordinated approach in which health, social and related support are organised around the needs of the person rather than delivered as disconnected sectoral interventions. Within SOLACE-CEE, IHSC may include healthcare, mental health support, social work, housing support, outreach, addiction care, employment or financial support, referrals and digital health, according to local needs and capacity.
TIC	Trauma Informed Care - An organisational and practice approach that recognises the prevalence and effects of trauma and seeks to increase safety, trust, transparency, choice, collaboration and empowerment while reducing practices that may cause re-traumatisation.
HF	Housing First - An evidence-informed approach that treats housing as a right and as the starting point for recovery rather than a reward for treatment or behavioural compliance. Core values include choice, separation of housing and support, recovery orientation, harm reduction voluntary engagement and individualised support. An

	evidence-informed approach that treats housing as a right and as the starting point for recovery rather than a reward for treatment or behavioural compliance. The SOLACE-CEE project follows internationally recognised Housing First principles and standards, including the guidance set out in the Housing First Europe Guide and supported by the Housing First Europe Hub. It also applies the lens of Housing First Values developed by the Housing First Poland Foundation, using these values as compass for implementing broader framework for integrating Housing First principles into health and social care practice. Core values include choice, separation of housing and support, recovery orientation, harm reduction, voluntary engagement and individualised support.
MDT	Multidisciplinary Team - A team or structured cooperation mechanism involving professionals from different disciplines who contribute complementary expertise to coordinated care.
NGO	Non-Governmental Organization
GP	General Practitioner
M&E	Monitoring and Evaluation
GDPR	General Data Protection Regulation
DEDO	Nadácia DEDO – DEDO Foundation
VPR	Všetci pre rodinu, n.o. – All for the Family NGO
MRI	Városkutatás - Metropolitan Research Institute
HCSOM	Magyar Máltai Szeretetszolgálat Egyesület / Hungarian Charity Service Of The Order Of Malta (HCSOM)
CI	Asociatia Casa Ioana

HESED	Health And Social Development Foundation
NMP	Fundacja Najpierw Mieszkanie Polska Housing First Poland Foundation
Integration HUB	A physical, organisational or coordinated service structure that acts as an accessible entry point into an integrated system of support. A HUB does not necessarily need to provide every service directly; it may combine direct provision with coordinated referrals and partnerships.
Person-Centred Care	An approach in which support is organised around the person's needs, priorities, preferences, capacities and circumstances, with respect for autonomy, dignity and shared decision-making.
Housing-Led Approach	A broader category of homelessness responses that prioritise rapid access to stable housing. Housing-led programmes may differ from Housing First in their target populations, support intensity, duration and degree of adherence to Housing First principles.
Low-threshold/low-barrier services	Services designed to reduce unnecessary physical, administrative, financial, behavioural and psychological barriers to access.
Care Pathway	The sequence and coordination of interactions, interventions, referrals and transitions through which a person accesses and receives support over time.
Continuity of care	The ability to maintain coherent and connected health and social support across different providers, settings and life transitions, including movement from street homelessness or temporary accommodation into stable housing.

Outreach	Proactive engagement and service delivery in locations where people live, spend time or access support rather than relying only on individuals presenting to formal services.
Telemedicine	Remote clinical care delivered through information and communication technologies. Within the PMG, telemedicine is treated as a complementary service modality rather than a replacement for necessary face-to-face care.
Remote Monitoring	The collection and review of health information or physiological measurements at a distance to support ongoing care, follow-up and early recognition of deterioration.
Lived experience	Knowledge arising from direct personal experience of homelessness, housing exclusion, healthcare and service systems. The PMG treats lived experience as an important form of knowledge for service design, evaluation and improvement.
Readiness/maturity	The extent to which an organisation, local ecosystem or system has the governance, workforce, partnerships, processes, infrastructure, resources and culture required to implement and sustain integrated care. The PMG uses the SCIROCCO Maturity Model as an important reference for considering readiness and maturity.
Practice Example	A short example from a SOLACE-CEE partner or implementation setting demonstrating how a methodological principle has been applied in practice.
Cross-cutting Case Study	A longitudinal case used across several chapters of the PMG to demonstrate how different elements of integrated care interact throughout a person's or family's pathway.

Timing and Scheduling Abbreviations

Abbreviations in document		Description
M1	Month 1 = 10/2024	October 2024
M2	Month 2 = 11/2024	November 2024
M3	Month 3 = 12/2024	December 2024
M4	Month 4 = 1/2025	January 2025
M5	Month 5 = 2/2025	February 2025
M6	Month 6 = 3/2025	March 2025
M7	Month 7 = 4/2025	April 2025
M8	Month 8 = 5/2025	May 2025
M9	Month 9 = 6/2025	June 2025
M10	Month 10 = 7/2025	July 2025
M11	Month 11 = 8/2025	August 2025
M12	Month 12 = 9/2025	September 2025
M13	Month 13 = 10/2025	October 2025
M14	Month 14 = 11/2025	November 2025
M15	Month 15 = 12/2025	December 2025
M16	Month 16 = 1/2026	January 2026
M17	Month 17 = 2/2026	February 2026
M18	Month 18 = 3/2026	March 2026
M19	Month 19 = 4/2026	April 2026
M20	Month 20 = 5/2026	May 2026
M21	Month 21 = 6/2026	June 2026
M22	Month 22 = 7/2026	July 2026
M23	Month 23 = 8/2026	August 2026
M24	Month 24 = 9/2026	September 2026
M25	Month 25 = 10/2026	October 2026
M26	Month 26 = 11/2026	November 2026
M27	Month 27 = 12/2026	December 2026
M28	Month 28 = 1/2027	January 2027
M29	Month 29 = 2/2027	February 2027
M30	Month 30 = 3/2027	March 2027
M31	Month 31 = 4/2027	April 2027
M32	Month 32 = 5/2027	May 2027
M33	Month 33 = 6/2027	June 2027
M34	Month 34 = 7/2027	July 2027
M35	Month 35 = 8/2027	August 2027
M36	Month 36 = 9/2027	September 2027

Short data sheet of the project

- **Project Name:** Solutions for Overcoming Homelessness through Integrated Care in the CEE Region
- **Project Acronym:** SOLACE-CEE
- **Project Number:** 101172625
- **Project Duration:** 36 months (01/10/2024 – 30/9/2027)
- **Funding Programme:** European Social Fund Plus (ESF+), call ESF-2023-HOMELESS; type of action ESF-PJG
- **Geographical involvement:** Poland, Slovakia, Hungary, Romania, Bulgaria
- **Coordinator:**
  - DEDO FOUNDATION (DEDO), Slovakia
- **Project Partners:**
  - Všetci pre rodinu, n.o. (VPR), Slovakia
  - MAGYAR MÁLTAI SZERETETSZOLGÁLAT EGYESÜLET (HCSOM), Hungary
  - HEALTH AND SOCIAL DEVELOPMENT FOUNDATION (HESED), Bulgaria
  - HOUSING FIRST POLAND FOUNDATION (NMP), Poland
  - Asociatia Casa Ioana (CI), Romania
  - VÁROSKUTATÁS (Metropolitan Research Institute) (MRI), Hungary

Executive Summary

Homelessness is not only the absence of housing. It is a multidimensional condition in which housing instability frequently intersects with poor physical and mental health, trauma, substance use, poverty, social exclusion, unemployment, legal and administrative barriers, and limited access to healthcare and social protection. For many people experiencing homelessness, these challenges accumulate over time and reinforce one another. As a result, needs that might be manageable within a stable living environment can develop into complex, persistent and mutually reinforcing health and social problems.

Service systems, however, are commonly organised in separate sectors. Healthcare, social support, housing, mental health, addiction treatment, employment assistance and other forms of support may operate through different institutions, eligibility rules, funding mechanisms and professional cultures. People with the most complex needs are consequently expected to navigate the most complex systems. The SOLACE-CEE project was developed in response to this structural mismatch. Its project design identified fragmentation of services, insufficient targeted healthcare, inadequate outreach, and weaknesses in data collection and advocacy as major barriers to improving outcomes for people experiencing chronic homelessness.

The **Project Methodology Guidelines (PMG)** provide a practical framework for organisations seeking to establish, strengthen or further integrate health and social services for people experiencing homelessness. As defined in the SOLACE-CEE project, Deliverable D5.5 is intended as a guide for NGOs operating within the homelessness sector, providing step-by-step instructions for establishing and implementing integrated healthcare and social services tailored to homeless populations.

The PMG goes beyond describing individual services. It focuses on the **architecture of integrated care**: how organisations can understand local needs, identify target groups, assess readiness, design appropriate service models, build multidisciplinary teams, establish pathways between health, social and housing services, embed Trauma-Informed Care, use digital health where it adds value, evaluate implementation, and progressively build the partnerships and conditions required for sustainability and system change.

The methodology is based on a whole-person understanding of homelessness. It recognises that physical health, mental health, housing, relationships, income, employment, social participation and other areas of life are interconnected. Effective support therefore requires coordinated responses that are organised around the person rather than around institutional or professional boundaries. The SOLACE-CEE methodological framework places person-centred care, dignity, autonomy, informed choice, continuity of support and flexible individualised interventions at the centre of service delivery.

Housing is treated as a foundation for health, recovery and social inclusion. The methodology is therefore strongly informed by **Housing First values**, including housing as a right, separation of housing and treatment, choice and self-determination, recovery orientation, harm reduction, voluntary engagement and individualised support adequate to person's diagnosis and goals. Housing should not be considered a reward for treatment success or behavioural compliance. For people with complex needs, stable housing and appropriately tailored health and social support should operate together.

Trauma-Informed Care (TIC) is embedded as a cross-cutting principle. People experiencing homelessness may have histories of violence, abuse, neglect, institutionalisation, loss, discrimination and prolonged insecurity. Services that fail to recognise these experiences may inadvertently reproduce fear, powerlessness, stigma or re-traumatisation. Trauma-informed services therefore seek to create physical and psychological safety, predictability, trust, choice, collaboration and empowerment, while recognising behaviour in the context of life experience rather than simply as non-compliance or resistance.

The methodology also incorporates **digital health, telemedicine and remote monitoring** as enabling tools. Digital solutions can improve access to consultations, specialist expertise, health monitoring, follow-up and professional coordination. They are not presented as substitutes for human contact. Their use must be clinically appropriate, accessible and embedded within wider care pathways, with attention to digital exclusion, health literacy, privacy, data protection and individual preferences.

A core principle of the PMG is that integrated care cannot be built by copying a single organisational model. SOLACE-CEE operates across different Central and Eastern European contexts with different healthcare systems, social protection arrangements, housing markets, legislation, workforce capacities and service infrastructures. The Guidelines therefore distinguish between **core principles that should remain stable** and **implementation arrangements that should be adapted to local conditions**.

The PMG is structured in three interconnected levels.

Level 1 – Conceptual Foundations explains homelessness, health inequalities, social determinants and the principles of Integrated Health and Social Care.

Level 2 – From Principles to Practice provides the step-by-step implementation pathway: understanding the local context, assessing needs and readiness, designing the service model, developing multidisciplinary teams and pathways, delivering services, embedding Trauma-Informed Care and digital health, and creating mechanisms for monitoring, learning and adaptation.

Level 3 – From Services to Sustainable Ecosystems moves beyond individual programmes to partnerships, governance, financing, legal and policy environments, data and evidence, replication, scaling and system change.

The Guidelines are designed as a **practice-oriented methodology rather than a linear textbook**. They combine conceptual explanation with implementation guidance, Partner Practice Examples, longitudinal Case Studies, checklists, templates, pathways and visual tools. The full PMG is complemented by a Quick Reference Guide and a Visual Toolkit to support practical use by organisations, service teams, managers, municipalities, policymakers and other stakeholders.

The underlying logic of the PMG is simple:

Understand → Implement → Build the Ecosystem → System Change.

At the same time, implementation should be understood as iterative rather than strictly linear. Needs assessment informs design; implementation generates evidence; monitoring identifies gaps; learning leads to adaptation; and mature practices can then be sustained, replicated and scaled. The SOLACE methodological framework summarises this continuous improvement logic as:

Assess → Design → Implement → Monitor → Learn → Adapt → Scale.

The ultimate ambition is therefore not simply to create better individual services. It is to contribute to a transition from fragmented responses towards integrated systems of care; from predominantly crisis-driven responses towards prevention, continuity and long-term stability; and from isolated innovations towards sustainable approaches capable of contributing to ending homelessness.

About SOLACE-CEE

SOLACE-CEE – Solutions for Overcoming Homelessness through Integrated Care in the CEE Region – is a European social innovation project focused on strengthening responses to homelessness through the integration of health and social care.

The project was developed from the recognition that people experiencing long-term or complex homelessness frequently require more than access to accommodation alone. While Housing First and housing-led approaches provide an essential foundation for ending homelessness, people with high and multiple support needs may also require accessible, coordinated and sustained health, mental health, addiction, social and other forms of support. The original project vision therefore proposed a continuum of care extending from street outreach to housing, supported by dedicated health and social teams, medical services, digital health and Trauma-Informed Care.

SOLACE-CEE is implemented across **five Central and Eastern European and Balkan countries: Slovakia, Hungary, Bulgaria, Poland and Romania**. The participating organisations bring complementary experience in homelessness services, Housing First, healthcare and social care, research, community-based support, digital health and capacity building. The project was designed specifically for contexts in which fragmented health and social systems, limited affordable housing and varying welfare capacities create significant barriers to effective responses to homelessness.

The project does not understand innovation as the introduction of a single new service. Its innovation lies in bringing together several mutually reinforcing approaches within an integrated framework. These include:

- coordinated health and social care;
- accessible and low-threshold services;
- outreach and community-based provision;
- multidisciplinary collaboration;
- Housing First values;
- Trauma-Informed Care;
- digital health, telemedicine and remote monitoring;
- participation of people with lived experience;
- data-informed service design;
- monitoring, evaluation and continuous learning;
- and the development of evidence for replication and system change.

At operational level, the project has tested different forms of integrated service provision according to local contexts. Integration HUBs or equivalent coordinated structures are understood as accessible entry points into wider systems of support rather than as isolated facilities. The methodological framework envisages that such

structures may provide or coordinate primary healthcare, mental healthcare, psychological support, social work, housing-related assistance, addiction services, outreach, specialist referrals, employment or financial counselling where relevant, and digital health solutions.

The five-country design is particularly important for the methodology. SOLACE-CEE does not assume that integration must look identical in every country. Different implementation environments make it possible to identify which elements of integrated care are essential and which can be adapted. The project therefore treats variation between countries and organisations as a source of learning rather than as a problem to be eliminated.

The Project Methodology Guidelines translate this experience into a framework that other organisations and systems can use. Replication is not understood as reproducing the exact organisational structure of one SOLACE-CEE partner. Instead, organisations are encouraged to transfer the **principles, processes, competencies, tools, implementation lessons and evaluation approaches** while adapting service arrangements to local conditions.

In this sense, SOLACE-CEE is both an implementation project and a learning process. Its longer-term ambition is to connect local innovation with professional practice, evidence generation, replication and policy development.

Purpose and Target Audience of the Guidelines

Purpose

The primary purpose of the Project Methodology Guidelines is to help organisations move from the intention to provide integrated care to its **practical implementation**.

Integrated care is often discussed as a desirable principle, but organisations may still face practical questions: *Where should we begin? Which population should the service target? How do we understand local needs? Which health and social services should be included? Does everything need to be delivered by one organisation? How do we establish cooperation with healthcare providers? How do we design low-threshold access? How should multidisciplinary teams work? What pathways should exist between outreach, healthcare, shelters, hospitals and housing? How do we maintain continuity when somebody moves from homelessness into permanent housing? How do we know whether the local system is ready? How can Trauma-Informed Care be translated from values into daily organisational practice? When does telemedicine add value, and when does it not? What should be monitored? How can a pilot service become sustainable? How can implementation evidence contribute to policy and system change?*

The PMG has been structured to respond to these questions progressively. It is intended to support organisations in:

- understanding homelessness and health through a holistic lens;
- assessing local population needs and existing service gaps;
- assessing organisational and system readiness;
- defining realistic objectives and target populations;
- designing accessible integrated service models;
- establishing Integration HUBs or equivalent coordinated structures where appropriate;
- building multidisciplinary teams and cross-sector partnerships;
- developing clear referral, care coordination and follow-up pathways;
- embedding Housing First values and Trauma-Informed Care;
- introducing digital health where it offers meaningful added value;
- strengthening professional capacities and supervision;
- establishing monitoring, evaluation and learning systems;
- using evidence to continuously improve services;
- planning for sustainability from the beginning;
- and supporting replication, scaling and system-level change.

The PMG should therefore not be understood as a rigid operational manual prescribing one standard model. It is a **framework for structured decision-making and implementation**. Its role is to help organisations ask the right questions, identify essential components, make context-sensitive choices, test these choices in practice and learn systematically from implementation.

Target Audience

The primary audience is **NGOs and non-profit organisations working with people experiencing homelessness**, in line with the original purpose of Deliverable D5.5.

However, integrated care necessarily involves actors beyond the homelessness sector. The Guidelines are therefore relevant to a wider range of professionals and organisations, including:

- homelessness service providers;
- Housing First and housing-led programmes;
- healthcare providers working with underserved populations;
- primary healthcare services;
- mental health and addiction services;
- outreach and street medicine teams;
- social service organisations;
- shelters and temporary accommodation providers;
- housing support organisations and social rental agencies;
- municipalities and regional authorities;
- hospitals and discharge planning teams;
- public health professionals;
- social workers and case managers;
- nurses, general practitioners, psychiatrists and psychologists;
- housing and employment specialists;
- peer workers and people with lived experience;
- service managers and organisational leaders;
- researchers and evaluators;
- funders and commissioners;
- policymakers and public authorities;
- and organisations considering the replication or scaling of integrated-care approaches.

Different readers will use different parts of the PMG. A frontline practitioner may focus primarily on care pathways, multidisciplinary working, Trauma-Informed Care and service provision. A service manager may use the sections on needs assessment, readiness, service design, staffing, monitoring and quality improvement. An organisational leader may focus on partnerships, governance, financing, data and sustainability. A municipality or policymaker may be particularly interested in ecosystem development, enabling policy environments, replication and system change. The PMG is therefore intentionally designed to allow **non-linear use**. Readers do not need to read every section before using the practical tools relevant to their work.

How to Use the Guidelines

The PMG can be used in several ways: as a step-by-step implementation guide, a reference document, a self-assessment framework, a training resource and a source of practical tools. For organisations starting from the beginning, we recommend following the implementation sequence in Level 2. Organisations that already operate integrated services may instead use individual chapters to review or strengthen specific aspects of their programme.

The Guidelines repeatedly distinguish between three types of content:

Principles – elements that define the orientation of integrated care and should remain consistent.

Implementation choices – organisational arrangements that should be adapted to local needs, resources and systems.

Practice learning – examples and experiences from SOLACE-CEE implementation that demonstrate how principles can be translated into real services.

Each chapter follows a broadly consistent internal logic:

Purpose and key concepts → Evidence and SOLACE approach → Implementation guidance → Practice Examples → Case Study application → Tools and checklists → Key messages.

This structure allows the reader to move from understanding a topic to applying it.

The practical tools included in the PMG are intended to support implementation rather than prescribe uniform procedures. Organisations should adapt templates, checklists and pathways to local legislation, professional competencies, governance arrangements and service capacity.

Introduction

Homelessness is one of the most complex and persistent social challenges facing European societies. It is not solely a question of housing, but a multidimensional phenomenon closely interconnected with poverty, social exclusion, unemployment, family instability, trauma, mental health difficulties, substance use and unequal access to healthcare and social services. For people experiencing homelessness, these challenges frequently accumulate and reinforce one another, creating complex situations that cannot be effectively addressed through isolated or fragmented interventions.

Access to healthcare is particularly challenging for people experiencing homelessness. Although this population often has significantly higher levels of physical and mental health needs than the general population, access to appropriate and continuous healthcare remains limited. Barriers may include the absence of health insurance or documentation, difficulties in navigating complex systems, lack of trust in institutions, previous negative experiences with services, mobility, stigma, discrimination and the practical challenges associated with maintaining appointments and treatment plans while living in unstable conditions. At the same time, health problems may themselves contribute to housing instability and make it more difficult for individuals to access employment, social protection and other essential services.

These interconnected challenges demonstrate the need to move beyond fragmented service delivery and towards integrated, person-centred and coordinated systems of care. Health and social services should not operate as separate and parallel systems, but should work together to respond to the complex and changing needs of people experiencing homelessness. Such an approach requires collaboration across professional disciplines, organisations and sectors, as well as a shared understanding of the specific needs and rights of the people being supported.

The SOLACE-CEE project – Solutions for Overcoming Homelessness through Integrated Care in the CEE Region – was developed in response to this challenge. Implemented across five Central and Eastern European countries, the project brings together organisations with complementary expertise in homelessness, Housing First, health and social care, research, community-based services, digital health and capacity building. The project aims to strengthen integrated responses to homelessness by developing and testing practical approaches that improve access to health and social services and by generating knowledge that can support replication and wider system change.

The SOLACE-CEE approach is based on the understanding that effective integrated care must be both holistic and individualised. It recognises that people experiencing homelessness are not a homogeneous group and that their needs, capacities and circumstances vary significantly. Consequently, integrated care cannot be reduced to a standard package of services. Instead, it should provide a flexible framework within which

different forms of support can be combined according to individual needs and local conditions.

At the centre of the SOLACE-CEE approach is the principle that the person should be considered as a whole. Physical health, mental health, housing, social relationships, financial circumstances, employment and other aspects of wellbeing are interconnected and should therefore be addressed through coordinated support. This perspective is reflected in the development of Integration HUBs and other integrated service structures, which aim to bring together health and social care, outreach and community-based support in a more accessible and coherent service environment.

The methodology is further informed by the principles and values of Housing First. Housing is understood as a fundamental basis for stability, recovery and improved health rather than as a reward that must be earned through compliance with treatment or support programmes. The approach therefore places emphasis on individual choice, dignity, autonomy, recovery, harm reduction and the right to housing. These principles provide an important foundation for establishing trusting relationships and for ensuring that support is organised around the needs and preferences of the individual.

Trauma-Informed Care represents a second essential pillar of the methodology. A significant proportion of people experiencing homelessness have experienced trauma, violence, neglect, abuse, loss or prolonged exposure to insecurity. Service systems that do not recognise these experiences may unintentionally create additional barriers to engagement or reproduce situations that undermine trust and safety. A trauma-informed approach therefore seeks to create environments in which people feel physically and psychologically safe, respected and empowered. It encourages professionals to understand behaviour in the context of individual life experiences and to avoid practices that may contribute to re-traumatisation.

A further component of the SOLACE-CEE methodology is the use of digital health solutions, including telemedicine and remote monitoring. Digital technologies can provide additional opportunities to overcome geographical, organisational and practical barriers to healthcare access, particularly for people living in areas where specialised services are scarce. At the same time, digital solutions should be implemented carefully and ethically. They should complement rather than replace human contact and face-to-face care, and their use should take into account digital exclusion, accessibility, privacy, data protection and individual preferences.

The methodology begins with an understanding of local needs and conditions. The SOLACE-CEE project therefore places strong emphasis on needs assessment, stakeholder engagement and the analysis of existing services and service gaps. The needs assessment provides an evidence base for designing interventions that are relevant to the realities of people experiencing homelessness and to the capacities of local service systems. In this way, the methodology follows a data-informed approach while recognising that

quantitative information must be complemented by qualitative knowledge and the lived experience of people directly affected by homelessness.

Implementation is understood as a continuous process rather than as a linear sequence of isolated activities. It involves mobilising and engaging people experiencing homelessness, assessing their needs, establishing coordinated pathways of support, implementing integrated services, developing professional capacities, monitoring results and adapting interventions based on feedback and evidence. The methodology therefore follows a continuous improvement cycle in which assessment informs design, implementation generates learning, and learning informs adaptation and further development.

An important characteristic of the SOLACE-CEE approach is its balance between common principles and local adaptation. The five participating countries differ considerably in terms of healthcare systems, housing markets, social protection structures, legislation, institutional capacities and existing homelessness services. A successful methodology therefore cannot prescribe one identical organisational model for every context. Instead, SOLACE-CEE seeks to identify the core principles and essential elements of integrated care while allowing individual implementation sites to adapt organisational arrangements, tools and service pathways to their local circumstances.

The methodology also recognises that sustainable change requires more than the establishment of individual pilot services. Integrated care needs to be embedded within wider systems and supported by appropriate professional capacities, institutional cooperation, sustainable financing and enabling policy environments. For this reason, the SOLACE-CEE approach includes capacity building, knowledge exchange, monitoring and evaluation, stakeholder engagement, dissemination and the development of tools that can facilitate replication and scaling.

The present methodology is therefore intended to provide a practical and adaptable framework for organisations and professionals seeking to develop or strengthen integrated health and social care for people experiencing homelessness. It brings together the knowledge, experience and lessons emerging from the implementation of SOLACE-CEE and translates them into a structured approach that can support future practice.

The methodology should not be understood as a fixed model. Rather, it is a framework for action and learning. Its central premise is that effective responses to homelessness require services to be person-centred, coordinated, trauma-informed, housing-oriented and responsive to individual and local needs. By combining these principles with systematic needs assessment, multidisciplinary cooperation, digital innovation, continuous evaluation and knowledge exchange, integrated care can contribute to improved health outcomes, greater housing stability and more inclusive and effective service systems.

Ultimately, the ambition of the SOLACE-CEE methodology extends beyond the delivery of individual services. It seeks to contribute to a broader transformation in the way homelessness is understood and addressed across Europe: from fragmented interventions towards integrated systems of care; from crisis responses towards prevention and early intervention; and from isolated local initiatives towards sustainable models that can be adapted, replicated and scaled. In doing so, the methodology aims to support not only better services for people experiencing homelessness, but also more coherent, equitable and sustainable European responses to homelessness and health inequalities.

I. LEVEL 1 — CONCEPTUAL FOUNDATIONS

Understanding Homelessness, Complex Needs and the Foundations of Integrated Care

Integrated Health and Social Care for people experiencing homelessness cannot begin with a discussion about staffing, clinics, referral forms or service schedules. It must begin with a clear understanding of **who the service is for, why existing systems often fail to respond effectively, and what principles should guide a different response**. This is the purpose of Level 1.

The SOLACE-CEE methodology starts from the premise that homelessness is not solely a housing problem and poor health among people experiencing homelessness is not solely a healthcare problem. Both are shaped by an interaction of housing conditions, poverty, health, trauma, social relationships, access to rights and services, institutional responses and wider structural conditions. These factors can accumulate over time and create needs that are simultaneously medical, psychological, social, housing-related, legal and economic. Conventional service systems are usually organised differently. Healthcare, social services, housing, employment, mental health, addiction services and income support are frequently organised through separate institutions, professional disciplines, funding streams and eligibility systems. The more complex a person's situation becomes, the more parts of this fragmented system they may be expected to navigate. Integrated care responds to this mismatch.

Its starting question is not:

Which service should this person fit into?

but rather:

What does this person need, and how should different services organise themselves around those needs?

This shift—from services to people, from isolated interventions to pathways, and from crisis management to long-term stability—is at the centre of the SOLACE-CEE methodology. The project Backbone accordingly begins with a holistic understanding of homelessness and health, places the person at the centre of service provision, incorporates Housing First and Trauma-Informed Care, and then translates these foundations into service design, multidisciplinary cooperation, outreach, continuity, learning and system change.

Level 1 develops this conceptual foundation through three chapters:

Chapter 1 explains homelessness and housing exclusion as diverse, dynamic and systemic phenomena.

Chapter 2 explores the health and social needs associated with homelessness and, crucially, how those needs interact.

Chapter 3 establishes the principles of Integrated Health and Social Care that guide the implementation methodology developed in Levels 2 and 3.

The aim is not to provide an exhaustive academic review of homelessness. The aim is to provide organisations with the conceptual understanding required to make sound implementation decisions later in the manual.

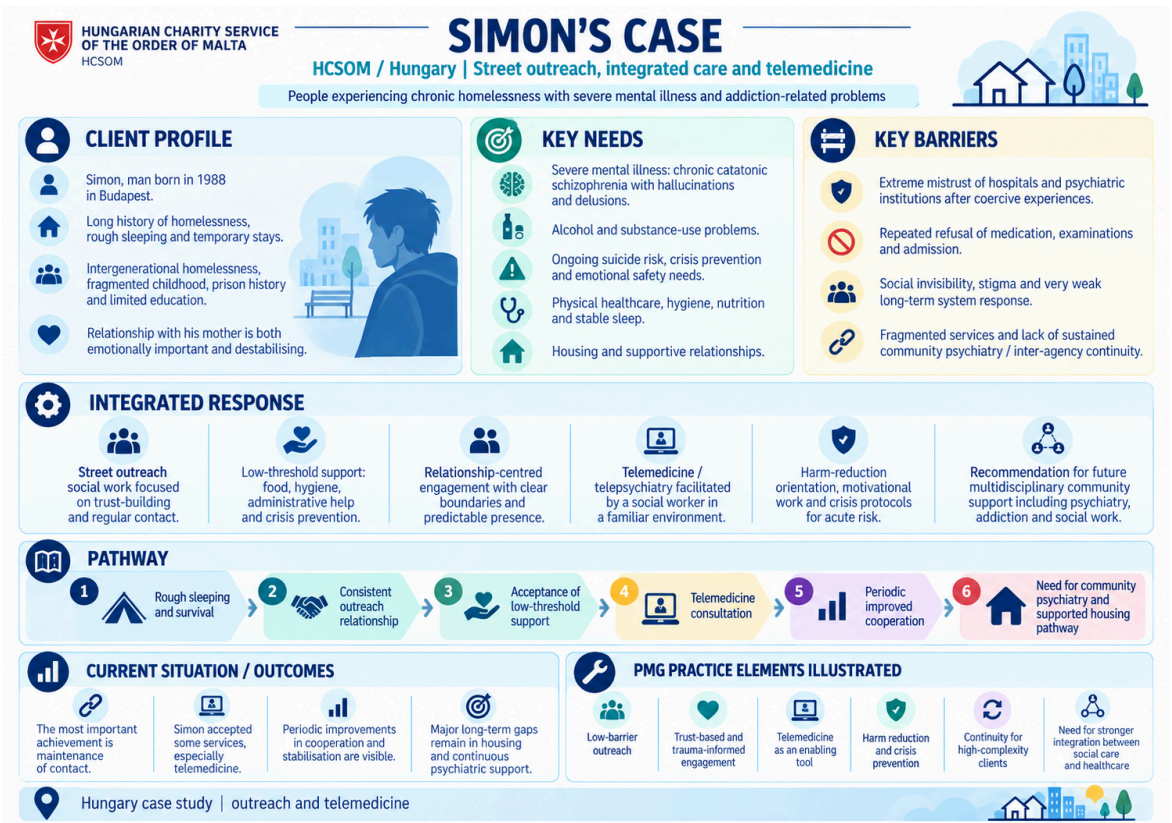
FIVE PEOPLE, FIVE CONTEXTS, ONE METHODOLOGY

Throughout the Guidelines, five cross-cutting cases illustrate how Integrated Health and Social Care may respond to different forms and stages of homelessness and housing exclusion. Each case is rooted in the practice context of one SOLACE-CEE implementation partner. The cases are intentionally different. They represent people living in rough sleeping and shelter homelessness, Housing First, informal settlements and inadequate housing, family shelters, and transitions from severe housing exclusion into permanent housing. They should not be interpreted as profiles of identifiable service users or as representations of every person supported by the respective organisations. They are **illustrative composite cases used for methodological learning**.

In Level 1, they help us understand **why integrated care is needed**. In Level 2, the same cases will illustrate **how integrated responses can be designed and implemented**. In Level 3, they will help explore **what partnerships, structures and system conditions are required to sustain those responses**.

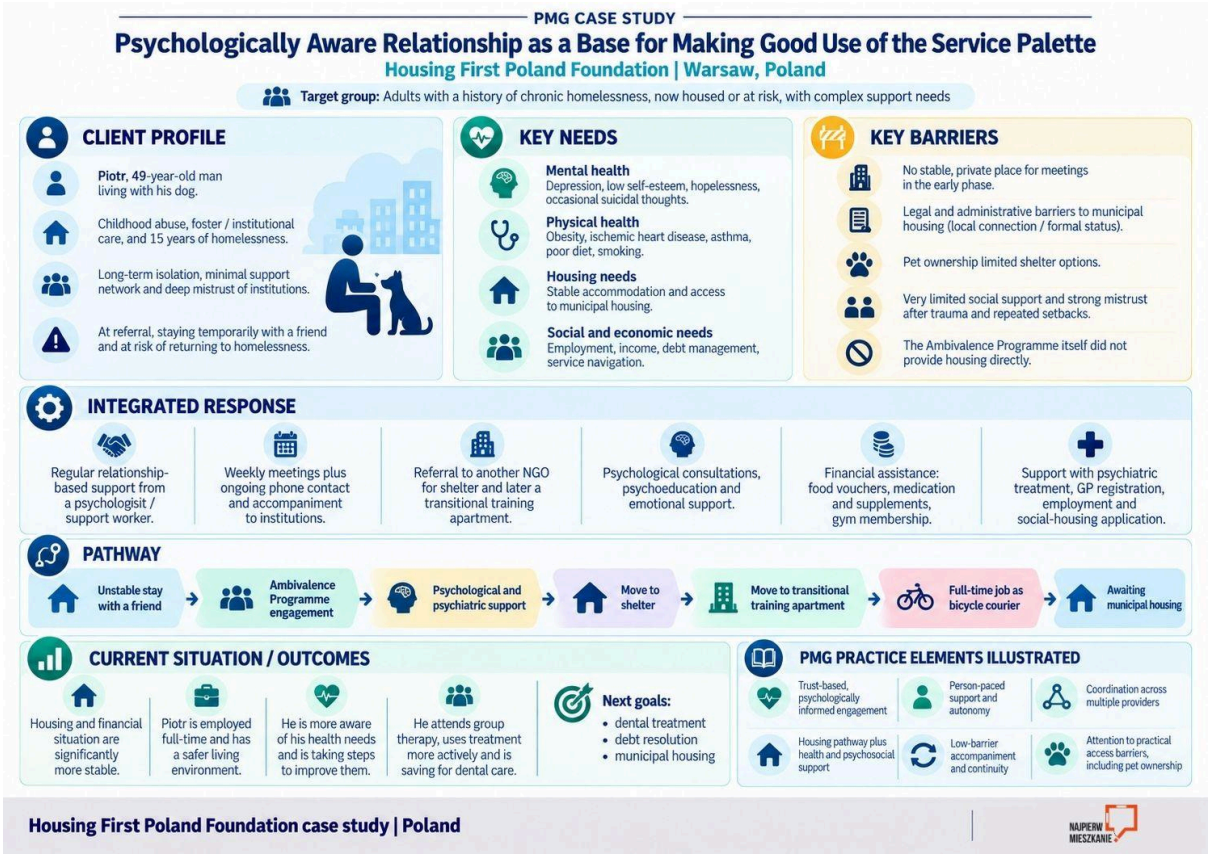
Hungarian Charity Service of the Order of Malta (HCSOM), Hungary — individuals experiencing rough sleeping and shelter homelessness.

The case follows an adult experiencing prolonged housing instability and moving between rough sleeping and emergency or shelter accommodation. Complex health and social needs, intermittent use of healthcare and barriers to conventional services provide a lens for examining outreach, accessibility, engagement and integrated care without stable housing.



Najpierw Mieszkanie Polska (NMP), Poland — individualised support based on through Housing First Values.

The case follows a person with a history of long-term homelessness and mental health crises who moves into permanent municipal housing while continuing to require health, mental-health and social support. It provides a lens for understanding housing as a foundation for recovery and the importance of continuing psychologically informed individualised support after homelessness ends.



Health and Social Development Foundation (HESED), Bulgaria — family living in an informal settlement or inadequate housing.

The case follows a family affected by severe housing exclusion, poverty, insecure living conditions and barriers to mainstream health and social systems. It provides a lens for understanding social determinants of health, community-based engagement, unequal access and family needs.



Casa Ioana Association (Casa Ioana), Romania — family living in shelter accommodation.

The case follows a mother and children living in temporary shelter accommodation, where health, psychosocial, safety and housing needs interact. It provides a lens for understanding family homelessness, trauma, safety and pathways from temporary accommodation towards longer-term stability.



Všetci pre rodinu, n.o. (VPR), Slovakia — continuity from homelessness and severe housing exclusion into Housing First.

The case follows a family whose pathway moves through severe housing exclusion and temporary accommodation towards permanent housing while health and social support continue throughout the transition. It provides a longitudinal lens for understanding continuity of care.



All complete cases are included in the Annexes section.

1. Understanding Homelessness and Housing Exclusion

Purpose of this chapter

Before deciding what an integrated service should provide, an organisation needs to understand **which forms of homelessness are present in its context, which populations may remain invisible, what pathways lead people into and out of homelessness, and where intervention is possible**. This chapter therefore treats homelessness not as a fixed personal characteristic, but as a housing and social situation that may change over time.

1.1. Understanding homelessness beyond the absence of a roof

The most visible image of homelessness is a person sleeping on the street. Rough sleeping is an important and particularly severe form of homelessness, but it represents only part of the population experiencing homelessness and severe housing exclusion. People may also live in emergency shelters, temporary accommodation, accommodation for people experiencing homelessness, institutions from which they have nowhere to move, informal or non-conventional dwellings, severely inadequate housing, or temporarily with friends and relatives because they lack a home of their own. This broader understanding is essential for integrated service design. If homelessness is defined only through visible street homelessness, organisations may unintentionally design services primarily around those who are already visible to outreach teams or emergency accommodation. Families, women, young adults, people leaving institutions and those living in informal or highly insecure housing may remain largely outside the service model. What a country or city counts as homelessness affects the apparent size and composition of its homeless population. What is not included in a definition may disappear from administrative statistics even though the underlying housing need remains. Therefore ETHOS Light is used as a common typology and structural understanding of homelessness. This allows for precise and concrete assessment of needs: **how homelessness is understood determines how services are subsequently designed.**

For the organisation using this manual, the first conceptual lesson is therefore straightforward:

Do not begin with the service you already provide. Begin with the population and housing situations that exist in your local context.

This principle becomes operational in Level 2 through population profiling, local context analysis and needs assessment.

CROSS-CUTTING CASES — Different housing situations, different forms of visibility
The five cases already demonstrate why a narrow definition of homelessness would be insufficient. The **HCSOM case** represents a person moving between rough sleeping and shelter accommodation. Homelessness is highly visible. The **Casa Ioana case** represents a mother and children living in temporary shelter accommodation. They have physical

shelter, but not a permanent home. The **HESED case** represents a family living in an informal settlement or severely inadequate housing. Their housing exclusion may not appear in conventional street-homelessness data at all. The **NMP case** begins with long-term homelessness but continues after the person has moved into permanent municipal housing and is receiving support in accordance with Housing First Values. The **VPR case** follows a family across several housing situations over time.

Together, these cases illustrate why integrated-care design must begin by asking **which housing situations and populations exist locally**, not by assuming one standard profile of a person experiencing homelessness.

1.2. ETHOS and the continuum of housing exclusion

The European Typology of Homelessness and Housing Exclusion (ETHOS) provides a useful framework because it moves beyond a binary distinction between being "housed" and "homeless". A home involves more than physical shelter. It includes an adequate physical space, a degree of legal security and the possibility of privacy, safety and social life. When these dimensions become insecure or disappear, people may experience different forms of housing exclusion.

The broad ETHOS framework distinguishes between:

- **rooflessness**;
- **houselessness**;
- **insecure housing**;
- **inadequate housing**.

ETHOS Light provides a more concise operational framework, including people living rough, people in emergency or temporary accommodation, people leaving institutions without housing, people in non-conventional dwellings and people temporarily staying with family or friends because they have nowhere else to live.

For a methodology focused on integrated care, the significance of these categories is practical. Different living situations influence:

- how people can be identified;
- where engagement must take place;
- what health risks may be present;
- which services they are already using;
- which administrative barriers they encounter;
- and what type of housing and support pathway may be realistic.

A street outreach programme will not identify all families living in hidden homelessness. A shelter-based clinic will not automatically reach people in informal settlements. A Housing First team supporting tenants may work with people whose homelessness has formally ended but whose health and social support needs remain substantial.

Integrated care therefore needs to follow the **continuum of housing exclusion and recovery**, rather than relying only on an administrative label.

CASE LENS — One continuum, five starting points
The five cases can be positioned at different points of this continuum:

HCSOM: rough sleeping ↔ emergency/shelter accommodation

Casa Ioana: temporary shelter accommodation

HESED: informal settlement / severely inadequate housing

NMP: long-term homelessness → permanent municipal tenancy → Housing First support

VPR: severe housing exclusion → temporary accommodation → Housing First

The categories help us understand the starting point. They should not become boundaries that prevent continuity once the person's housing situation changes.

1.3. Homelessness has structural, institutional and individual dimensions

Homelessness should not be explained through a single type of cause. The PMG deliberately distinguishes among **structural factors, institutional pathways and individual vulnerability factors**. Structural factors include poverty, lack of affordable housing, labour-market exclusion and broader inequalities. These influence how easy it is for households to obtain and retain housing and how much resilience they have when income, relationships or health deteriorate. Institutional factors include failures at points where people move between systems. Discharge from hospital without appropriate accommodation, leaving institutional care, prison or other residential settings without housing, and fragmented cooperation between institutions can all contribute to homelessness.

Individual and family circumstances may include illness, trauma, disability, substance use, relationship breakdown, violence, loss, unemployment and other events that increase vulnerability. These dimensions should not be treated as competing explanations. They interact. A person with severe mental health difficulties living in a housing market with sufficient affordable housing and strong community support may remain housed. The same health condition in a context of poverty, unaffordable rent, fragmented services and no family support may contribute to homelessness. Similarly, a relationship breakdown may become a short-term housing disruption for a person with financial resources and social networks, but a pathway into prolonged homelessness for somebody without either. For service organisations, this matters because **individual support cannot substitute for structural solutions**. Excellent case management cannot create affordable housing where none exists. Psychiatric treatment cannot eliminate discriminatory rules.

Social work cannot by itself reform fragmented health and welfare systems. Integrated care therefore operates at several levels: at the **person level**, by coordinating appropriate support; at the **service level**, by reducing fragmentation; and ultimately at the **system level**, by using implementation evidence to advocate for structural change. This movement from individual care towards ecosystem and system change is embedded throughout the SOLACE Backbone.

CASE LENS — The HESED family: when a health problem is also a housing problem

The HESED case illustrates why individual and structural explanations cannot be separated. A child may repeatedly experience respiratory problems. Clinical treatment is necessary. Yet if the family continues to live in damp, overcrowded or otherwise inadequate conditions, the housing environment may continue to reproduce the risk. The integrated response therefore asks two questions simultaneously:

What healthcare is needed now?

and

What conditions are contributing to the need for healthcare?

Neither question replaces the other.

1.4. Homelessness is a pathway, not an identity

People do not simply become members of a permanent category called "the homeless". They move through different housing situations. A trajectory may involve secure housing, increasing housing stress, temporary arrangements with relatives, emergency accommodation, rough sleeping and eventually permanent housing. Another pathway may move directly from an institution into homelessness. A family may alternate between informal accommodation and shelters. Someone may experience several episodes of homelessness separated by periods of housing. Understanding homelessness dynamically has several implications. The PMG therefore includes trajectories and stages of homelessness as part of the conceptual foundation.

Prevention becomes part of homelessness policy

If homelessness is a pathway, intervention does not have to begin once a person sleeps rough. Rent arrears, eviction procedures, discharge from hospital, leaving institutional care, family violence, loss of income or rapid deterioration in health may all signal increased risk. An integrated system should therefore be capable of identifying critical transition points.

The intensity of support may change over time

Needs may be very different during a crisis, early housing stabilisation and longer-term recovery. Integrated care must be flexible enough to respond to these changes rather than prescribing one fixed package.

Housing does not necessarily end support needs

One of the structural problems identified in the SOLACE-CEE proposal is that people moving from homelessness into housing can lose access to homelessness-specific services precisely when they are adjusting to a major transition. The proposal highlights the need for longer-term psychological, motivational and social-integration support during this period.

Integrated care principles consequently make **continuity of care when housing situations change** an explicit methodological requirement: moving into stable housing should not automatically mean losing established therapeutic and social relationships.

This is a key principle of the entire PMG:

Integrated care follows the person across changes in housing status.

CROSS-CUTTING CASE — VPR: the pathway continues after the key is handed over
The VPR case provides a longitudinal illustration:

Severe housing exclusion

→ outreach and engagement

→ **temporary or shelter accommodation**

→ health and social support

→ **housing pathway**

→ Housing First / permanent housing

→ **continued health, social and housing support**

→ stabilisation and community integration.

The family's housing status changes repeatedly. The person, health history and established relationships with services do not. This case will therefore return throughout the PMG whenever continuity across settings becomes important.

1.5. Rough sleeping and entrenched homelessness

People sleeping rough often experience some of the most severe barriers to conventional health and social services. Daily priorities may focus on safety, food, shelter, warmth, hygiene and protecting personal belongings. Managing appointments, storing medication, following complex treatment plans or maintaining contact with several institutions can be extremely difficult under these conditions. Exposure to weather, violence, disrupted sleep, poor nutrition and unsafe environments may further deteriorate health.

The project proposal specifically focused on people experiencing chronic homelessness and multimorbidity because this group often has high-intensity support needs that cannot be addressed through housing alone. The project vision therefore combined housing-led

responses with wraparound health, mental health, addiction, social and other support, delivered along a continuum extending from street to housing. For this population, outreach is particularly important.

SOLACE-CEE identifies relationship-based outreach as a fundamental component of integrated care. Services should actively engage people in streets, temporary accommodation, shelters, settlements and community settings rather than make support dependent on the person's capacity to navigate institutional systems. This principle is broader than street outreach. It means that **services carry part of the responsibility for engagement**. The person should not have to demonstrate organisational competence before receiving support.

CROSS-CUTTING CASE — HCSOM: when waiting for the person to arrive is not enough
For the person represented by the HCSOM case, the existence of a clinic does not automatically produce access to care. A conventional pathway may assume that the person can identify a health problem, arrange an appointment, travel to the service, arrive at the expected time, retain documentation and medication, and return for follow-up. Rough sleeping may make several of these assumptions unrealistic. Outreach therefore becomes more than service promotion. It becomes a mechanism through which the system shares responsibility for creating access.

1.6. Shelter and temporary accommodation

Emergency shelters and temporary accommodation can provide immediate protection from rough sleeping, but they should not be confused with a permanent solution to homelessness. The SOLACE-CEE explicitly challenges systems overly dependent on emergency and temporary accommodation and situates SOLACE-CEE within the broader transition towards Housing First and housing-led approaches.

From a health perspective, temporary accommodation may nevertheless create important opportunities. It can provide a location for:

- primary healthcare;
- mental health support;
- nursing;
- health screening;
- case management;
- benefits assistance;
- housing navigation;
- digital consultation;
- and connection with specialist services.

At the same time, the institutional environment may itself affect health and wellbeing. Shared environments can complicate privacy, sleep, hygiene, infection control and recovery. Rules, uncertainty about length of stay and lack of autonomy can also affect psychological wellbeing.A manual for integrated care should therefore treat shelters

neither as failures nor as endpoints. They are **one possible location within a wider pathway**, and the aim should remain movement towards safe, adequate and sustainable housing.

CASE LENS — Casa Ioana: shelter as a point in the pathway, not the destination
For the family represented by the Casa Ioana case, shelter accommodation can provide immediate safety and a place from which coordinated support becomes possible. But the family's pathway cannot end with temporary accommodation. Health, psychosocial support, family stability, income, safety and housing planning need to be considered together so that shelter becomes a **transition point towards longer-term stability**, rather than a permanent service destination.

1.7. Family homelessness

Family homelessness requires a different lens from models designed primarily around single adults. Families may enter homelessness through eviction, poverty, domestic violence, relationship breakdown, overcrowding or prolonged housing insecurity. They may live in shelters, informal settlements, temporary accommodation or hidden arrangements. Needs occur simultaneously at several levels. Parents may have physical or mental health needs, histories of trauma, employment or income problems, legal difficulties and housing needs. Children may require healthcare, developmental support, stable education, nutrition, emotional security and protection. Housing conditions affect the entire household. Supporting a family therefore requires attention not only to individual diagnoses or social problems but to the functioning and stability of the household as a whole. A family-centred integrated approach may need to connect: adult healthcare; paediatric care; mental health and psychological support; social work; housing; benefits; employment support; safeguarding; education; and legal assistance. The exact combination will vary. The principle does not.

When the unit experiencing homelessness is a family, the service pathway must recognise both individual needs and household interdependence.

This is particularly relevant to the SOLACE-CEE cases contributed by partners working with families in shelters, informal settlements and transitions into permanent housing.

CASE COMPARISON — HESED, Casa Ioana and VPR
Three cross-cutting cases focus on families, but their starting conditions differ. The **HESED family** demonstrates the interaction of health, poverty, community context and inadequate housing. The **Casa Ioana family** illustrates needs associated with temporary shelter accommodation, safety, trauma and family stabilisation. The **VPR family** illustrates how support can continue across movement from severe housing exclusion and temporary accommodation into permanent housing. Their service pathways should therefore not be identical. Their shared feature is that the **family**, rather than only an individual adult, becomes the relevant unit of integrated planning.

1.8. Hidden homelessness

Visibility is one of the central methodological problems in homelessness. Services tend to know the people who use them. This can create a circular problem: existing service users generate the data; the data define the target population; future services are then designed around the same users. People outside the system remain invisible. Hidden homelessness may include people temporarily staying with family, friends or partners because they have nowhere else to live. Women and families may remain in unsafe or highly insecure arrangements to avoid street homelessness or emergency shelters. Some people may not identify themselves as homeless. Others may avoid formal services because of stigma, previous negative experiences, fear of authorities or concerns about children. This means that local needs assessment cannot rely only on service statistics.

Integrated care explicitly requires structured needs assessment using both quantitative and qualitative information and involving people experiencing homelessness as well as professionals. It also requires data to inform subsequent decisions on services, staffing, outreach, location, referrals, digital health and partnerships.

Level 2 will translate this principle into a practical methodology. At this conceptual stage, the message is:

The population visible to your organisation is not necessarily the population in need.

CASE LENS — Visibility depends on where the system looks

The **HCSOM case** is comparatively visible because rough sleeping and shelter use may bring a person into contact with homelessness services. A family represented by the **HESED case** may remain almost entirely outside conventional homelessness services while experiencing severe housing exclusion. A family may also move through informal arrangements before reaching a shelter such as the one represented in the **Casa Ioana case**. The population identified through one service therefore cannot automatically be assumed to represent the local population experiencing homelessness or housing exclusion.

1.9. Informal settlements and inadequate housing

Inadequate housing sits at the boundary between homelessness, housing exclusion and public health. A household may have a roof but lack adequate sanitation, water, heating, safety, privacy, secure tenure or sufficient space. Informal settlements can also be geographically or institutionally disconnected from mainstream services. These conditions matter directly for health. Poor housing may contribute to respiratory illness, infectious disease, injury, chronic stress and difficulty maintaining hygiene or managing chronic conditions. It also affects what a health professional can realistically recommend. Advice that assumes safe storage, refrigeration, running water, adequate food or privacy may not be feasible.

For organisations using this manual, the housing assessment should therefore ask not simply:

Does the person have accommodation?

but:

Is that accommodation safe, adequate, secure and capable of supporting health and recovery?

This distinction becomes particularly important for prevention and for work with families.

CROSS-CUTTING CASE — HESED: having a roof is not the same as having adequate housing

The HESED case provides an important reminder that a family can be physically sheltered while still living in conditions that undermine health and stability. The integrated response therefore needs to consider housing quality as part of the health and social context rather than classifying the family simply as "housed".

1.10. Institutional pathways into homelessness

Transitions from hospitals, psychiatric institutions, prisons, care institutions and other residential systems can create a direct pathway into homelessness when no adequate accommodation is available. These situations expose a central weakness of fragmented systems. Each institution may technically complete its own mandate while the overall pathway fails the person. A hospital may complete medical treatment but discharge somebody to homelessness. A social institution may close a case without an effective housing transition. A housing service may refuse a person because health needs appear too complex. No single institution necessarily perceives itself as responsible for the resulting homelessness. Integrated care challenges this logic by focusing on **shared outcomes across institutional boundaries**. This is why hospital discharge planning, warm handovers, case coordination and transition pathways later become explicit components of the implementation methodology.

CASE QUESTION — Where does responsibility end?

The HCSOM and NMPcases can both be used to ask a system-level question that will return later in the PMG: If a person receives clinically appropriate treatment in hospital but is discharged back to rough sleeping, shelter homelessness or another unstable environment, **has the care pathway actually succeeded?** Integrated care requires institutions to examine not only whether their individual intervention was completed but whether the transition to the next part of the person's pathway is viable.

1.11. Intersectionality and diversity within homelessness

There is no single profile of a person experiencing homelessness. People differ in: age; gender; family status; health; disability; ethnicity; migration background; sexual orientation and gender identity; experiences of violence; institutional histories; length of homelessness; housing history; education; employment; social networks; and service experience. These characteristics may intersect. The result is not simply "more vulnerabilities", but potentially different patterns of exclusion and different service needs. A woman experiencing homelessness after domestic violence may need an environment where physical and relational safety are central. A young adult leaving institutional care may need help developing independent-living skills and social networks. A person with mobility impairment may be unable to use physically inaccessible services. A family in an informal settlement may require community-based engagement rather than conventional homelessness outreach. A person with severe mental illness and prolonged rough sleeping may need intensive and persistent multidisciplinary support. A person with previous discriminatory experiences may avoid services that appear accessible on paper.

For the manual, intersectionality has one especially important implication:

Universal service design must be combined with the capacity to adapt support to different barriers and needs.

This is closely connected to the second Integrated Health and Social Care core principle: Low-Barrier and Equitable Access.

CASE COMPARISON — Equal services would not create equal access
The **HCSOM case** may require proactive outreach and flexible access because rough sleeping creates barriers to scheduled institutional care. The **HESED case** may require community-based engagement because geography, poverty, discrimination, family responsibilities or administrative barriers shape access. The **Casa Ioana case** may require particular attention to safety, privacy and trauma. Providing the same standard appointment pathway to all three would technically constitute equal treatment. It would not necessarily constitute **equitable access**.

1.12. Stigma, stereotypes and professional attitudes

Homelessness is not experienced only through material deprivation. People may also encounter stigma and negative assumptions within wider society and within services. The PMG deliberately includes myths, stereotypes and stigma because professional attitudes directly influence access and engagement. People may be characterised as: “difficult"; "non-compliant"; "unmotivated"; "chaotic"; "not ready"; or "responsible for their situation". Such labels can obscure the realities of trauma, competing survival priorities, cognitive difficulties, mental illness, mistrust created by previous service experiences or simple organisational barriers.

The underlying IHSC work that informed SOLACE-CEE emphasises the importance of trusting and respectful relationships, non-judgemental care and provider understanding of the comprehensive needs of people experiencing homelessness. It also frames the response as one grounded in social justice rather than charity. This has profound implications for implementation. Changing service structure without changing professional attitudes may leave the core barrier untouched. Integration is therefore not solely about systems and processes. It is also about **how people are seen and treated within those systems**.

CASE QUESTION — Non-compliance or inaccessible care?

If the person represented by the HCSOM case repeatedly misses appointments, the service can label this behaviour as "non-compliance". An integrated-care perspective asks additional questions. Was the appointment reachable? Did the person know when and where to attend? Did they have transport? Could they safely store the documents or medication? Was previous contact with the service respectful? Did competing survival needs take priority? The purpose is not to remove individual agency. It is to avoid interpreting a system-access problem solely as an individual behavioural problem.

2. Health and Social Needs of People Experiencing Homelessness

Purpose of this chapter

The second conceptual foundation concerns complexity. A service cannot become integrated simply by expanding the number of interventions it offers. It needs to understand **how health, housing and social needs influence each other and why effective care must respond to these interactions**. The SOLACE-CEE project arose from exactly this challenge. Its proposal identified people with chronic homelessness and multimorbidity as a group for whom fragmented healthcare and social services are particularly inadequate.

2.1. Social determinants of health: why healthcare alone is insufficient

Health is produced not only in clinics and hospitals. Housing, income, nutrition, employment, relationships, education, social inclusion, safety and access to services all influence health. Homelessness represents an extreme condition in which several of these determinants may be unstable at the same time.

Consider the management of an ordinary chronic condition such as hypertension or diabetes. Good clinical management assumes the ability to: obtain medication; store medication; take it regularly; eat with reasonable consistency; monitor symptoms; attend

follow-up appointments; understand instructions; and contact a professional when the condition changes. Homelessness can disrupt each of these conditions.

The SOLACE-CEE project needs analysis to explicitly identify lost or stolen medication and lack of a safe or clean place to manage illness among barriers affecting people experiencing homelessness. It also identified severe fragmentation between acute treatment and chronic disease management. The problem is therefore not that medical treatment is irrelevant. It is that clinical effectiveness depends partly on social conditions. Integrated care does not ask a physician to solve housing problems or a social worker to become a clinician. It ensures that each professional understands how the other domain affects the person's outcomes and that mechanisms exist to respond jointly when needed.

CASE LENS — Follow the person, not the diagnosis

For the person represented in the **HCSOM case**, prescribing medication for a chronic condition may be clinically correct but practically insufficient if medication cannot be safely stored, follow-up is inconsistent or rough sleeping makes the treatment plan difficult to maintain. For the **HESED family**, treating a child's recurrent respiratory symptoms may be necessary while inadequate housing conditions continue to contribute to those symptoms. For the person represented in the **NMP case**, permanent housing changes the environment in which healthcare can be provided but does not automatically remove health needs accumulated during long-term homelessness. These cases demonstrate why clinical care and the social context should be understood together.

2.2. Health inequalities and cumulative disadvantage

People experiencing homelessness commonly face a high burden of physical and mental illness while simultaneously encountering barriers to appropriate care. The underlying research used in developing the SOLACE_CEE framework describes integrated care as a response to fragmented systems unable to apply the whole-person approach required by people with complex needs. It links integrated care to a human-rights perspective and recognition of social determinants of health. Health inequality in homelessness should therefore not be understood simply as a collection of individual risk behaviours. It is produced through **cumulative disadvantage**. Poor housing affects health. Poor health affects employability and income. Low income restricts housing options. Mental illness may make administrative systems difficult to navigate. Stigma may discourage healthcare use. Repeated crisis treatment without follow-up may worsen long-term outcomes. Trauma may influence trust. Lack of transport can turn a technically available appointment into an inaccessible service. The integrated-care response seeks to interrupt these reinforcing loops.

CASE COMPARISON — Different pathways to inequality

The **HCSOM case** may demonstrate cumulative disadvantage through prolonged exposure to rough sleeping, repeated crisis care and difficulty sustaining treatment. The **HESED case** may demonstrate it through poverty, inadequate housing and unequal access to

mainstream services affecting an entire family. The **Casa Ioana case** may demonstrate how homelessness, family vulnerability, trauma and safety can interact. The mechanism differs. The methodological implication is the same: **health inequality is generated by interacting conditions, not merely by individual diagnosis or behaviour**.

2.3. Multimorbidity: when separate diagnoses become one complex care problem

The PMG places particular emphasis on multimorbidity because the presence of several conditions simultaneously has consequences beyond the number of diagnoses. A person may have: a cardiovascular condition; chronic respiratory illness; an untreated wound; depression; alcohol dependence; and unstable housing. Each individual need might have an established service response. The difficulty emerges from their interaction. Medication may interact with substance use. Mental health difficulties may affect adherence. Poor housing may worsen respiratory health. Pain may contribute to substance use. A missed appointment may lead to discontinuity across several conditions at once. The person may receive recommendations from professionals who do not know about one another. Integrated care addresses multimorbidity not by eliminating specialisation, but by adding **coordination and shared understanding**. This is a crucial distinction. The aim is not to create one "super-professional" capable of solving every problem. The aim is to prevent the burden of coordinating multiple specialised services from falling entirely on the person with the most complex needs.

CROSS-CUTTING CASE — HCSOM: several needs, one person

Imagine the **HCSOM case** involving chronic physical illness, mental-health difficulties, harmful substance use and unstable accommodation. A fragmented system may generate several technically correct referrals. An integrated system asks how these needs interact, which needs are urgent, what can realistically be addressed first, which professionals need to coordinate and who will maintain continuity. This distinction—between multiple services and integrated care—will become operational in Level 2.

2.4. Physical health needs

Physical-health needs among people experiencing homelessness can include both chronic and acute conditions. The IHSC curriculum identifies cardiovascular disease, diabetes and respiratory disease alongside infectious diseases such as tuberculosis, HIV, hepatitis and skin conditions. A manual for integrated care should not treat this as a diagnostic catalogue. The methodological question is what these health needs mean for the design of care.

Primary care matters

Many conditions require continuity rather than emergency treatment. Accessible primary healthcare can provide a stable clinical relationship, preventive care, chronic-disease management and a gateway to specialist services.

Preventive care matters

People experiencing homelessness should not be restricted to crisis medicine. Screening, vaccination, health promotion and early intervention remain important.

Specialist pathways matter

Primary care alone cannot address all needs. Effective referral and follow-up mechanisms are necessary.

Recovery environments matter

Some medical conditions cannot be managed safely while sleeping rough or in unstable environments. The underlying Health Care for the Homeless model informing SOLACE-CEE includes **medical respite care** as part of a broader comprehensive service architecture, providing a bridge where medically vulnerable people need time and support to recover outside hospital but cannot safely recuperate on the street.

Practical support matters

Transportation, accompaniment, communication, medication support and case management may determine whether a clinical recommendation becomes actual care. This demonstrates a recurring principle:

Health services become accessible not only by opening a clinic, but by designing the pathway around the realities of the population.

CASE LENS — The same treatment needs different support conditions

A specialist appointment may be clinically appropriate for both the person represented by **HCSOM** and the person represented by **NMP**. For somebody sleeping rough, accessing that appointment may require outreach engagement, appointment coordination, transport or accompaniment. For somebody living in Housing First, stable housing may make attendance easier, but support may still be required because of mental-health, cognitive or other barriers. Integrated care therefore adapts the pathway without lowering the standard of healthcare.

2.5. Mental health

Mental health and homelessness have a bidirectional relationship. Mental illness can increase vulnerability to housing loss and make navigation of complex systems more difficult. Homelessness can worsen existing mental illness and expose people to prolonged stress, violence, isolation and insecurity. For integrated care, the important point is that mental health should not be separated from physical health, housing and social support. A psychiatric intervention may stabilize symptoms while the person continues living in conditions that reproduce distress. Housing may improve safety while untreated mental illness undermines the ability to maintain daily routines. A hospital admission may resolve an acute crisis but discharge into homelessness may immediately recreate instability. Integrated care therefore requires mental healthcare to be embedded within wider pathways. Depending on local context and population needs, this may involve

embedded psychiatry or psychology, close referral relationships, joint case conferences, outreach mental healthcare, telepsychiatry or specialist consultation. The model must follow the need.

CASE LENS — NMP: housing changes the context, not the need for care

In the **NMP case**, moving into a municipal tenancy with the support provided in accordance to Housing First Values may fundamentally improve stability without automatically resolving mental-health needs accumulated during long-term homelessness. The support system therefore needs to remain available after housing rather than treating the tenancy as evidence that all other needs have ended.

2.6. Substance use, harm reduction and integrated care

Substance use is one of the areas where service philosophy becomes especially important. Traditional systems may require abstinence or treatment compliance before access to housing or other services. The Housing First principles take a different position. Housing and support are separated, harm reduction is prioritised, and engagement is active but non-coercive. This does not mean ignoring risks. It means that reducing harm and maintaining a relationship may be clinically and socially more effective than making support conditional on immediate abstinence. Substance use may also be inseparable from other needs. It may interact with trauma, untreated pain, severe mental illness, social isolation or coping with street homelessness. Integrated care therefore avoids service sequences in which one need must be completely resolved before another can be addressed. A person can require housing, primary care, addiction support and mental healthcare at the same time. The service system should be capable of holding this complexity.

CASE COMPARISON — HCSOM and NMP

The **HCSOM case** can illustrate harm reduction while somebody remains in unstable housing or rough sleeping. The **NMP case** illustrates the same principle within Housing First Value based support: permanent housing is not made conditional on first resolving substance-use or mental-health needs. The setting changes. The principle of non-coercive, person-centred support remains.

2.7. Trauma as a health, relational and organisational issue

Trauma is not an isolated mental-health topic within SOLACE-CEE. It is a cross-cutting component of the entire methodology. Integrated care explicitly requires Trauma-Informed Care to be embedded across the service system rather than restricted to specialist mental-health interventions. It highlights physical and psychological safety, trust, predictability, prevention of re-traumatisation, recognition of trauma's effects on behaviour and participation, and strengthening agency and empowerment. The TIC principles develop this further by framing trauma-informed care as a way of understanding and responding rather than a single clinical technique. This matters

particularly in homelessness. Systems themselves may become sources of stress. A crowded waiting room, unpredictable rules, repeated demands to retell traumatic experiences, abrupt professional communication, unexplained decisions or threats of losing services may recreate feelings of powerlessness. Trauma-informed practice therefore asks services to examine not only the person, but themselves: *Does our environment feel safe? Are procedures predictable? Do people understand what will happen next? Are choices offered where possible? Are rules explained? Are boundaries clear and respectful? Do people need to repeat painful histories unnecessarily? Does our communication reduce or increase shame?* This is why TIC later appears both as a cross-cutting element of service design and as a dedicated implementation chapter.

CROSS-CUTTING CASE — Casa Ioana: what does the service feel like from the other side?

Consider a mother represented by the **Casa Ioana case** entering a new service with her children. Several professionals may legitimately need information. If each professional independently asks the family to explain difficult or traumatic experiences, the organisation may perceive this as appropriate assessment while the family experiences repetition, uncertainty and loss of control. A trauma-informed pathway asks whether the same necessary information can be obtained and shared in a way that increases **safety, transparency, predictability and agency**.

The case therefore shifts the focus from *what information does the service need?* to also asking *how is the process experienced by the person?*

2.8. Health literacy, service literacy and the ability to navigate care

Access requires more than eligibility. People must understand how systems work, what professionals are asking, why treatment matters, where to go next and what will happen after a referral. Limited health literacy can create barriers, but so can **service complexity**. A person should not be described as "unable to navigate services" without asking whether those services are unnecessarily difficult to navigate. The SOLACE-CEE project identifies complex and scattered systems themselves as a barrier. Integrated care therefore redistributes some navigation responsibility from the service user to the system. Case management, accompaniment, warm handovers, clear communication and no-wrong-door approaches are practical ways to achieve this.

CASE QUESTION — Who is doing the integration?

If the person represented by the **HCSOM case** receives five referrals from five different professionals, the system may describe the response as comprehensive. If the person must independently arrange, understand and complete all five pathways, the burden of integration still rests with them. Integrated care asks the system to assume part of that coordination responsibility.

2.9. Housing as a health intervention

The relationship between housing and health is central to SOLACE-CEE. Housing provides: safety; privacy; sleep; hygiene; stability; space for medication; possibility of recovery; and a location from which consistent healthcare becomes easier. The Health Care for the Homeless work underlying SOLACE-CEE uses the powerful formulation that **housing is healthcare**, reflecting the reality that many health interventions cannot achieve their full effect while housing remains unstable. This does not mean that every health problem resolves once someone is housed. Indeed, the transition into housing may reveal needs previously obscured by the urgency of street survival. Mental health symptoms may become more visible. Loneliness may increase. Substance-use patterns may change. Daily routines need to be rebuilt. Long-neglected chronic illnesses still require treatment. Housing therefore functions as both an outcome and a **platform for recovery**.

CROSS-CUTTING CASE — NMP: Housing First does not mean housing only

The **Fundacja NMP case** demonstrates the power of housing stability the heart of the effectiveness of Housing First. Instead of expecting intensive use of services and healing during unstable housing situations, the support is concentrated on building trust to the support worker and improving psychological self-awareness of needs, goals, health and own potential. Improved awareness becomes a baseline for better decisions and more service use. Once permanent housing becomes available, it changes the conditions for further recovery. Integrated support remains available because receiving a key is not an end of the healing process. On the contrary, the key opens the door to new challenges which need to be addressed including full responsibility for decisions, financial obligations, navigating local services, neighbourhood rules and loneliness.

Instead of:

expectation to use services while in the street → improvement of health

the pathway begins with:

building trust based relationship → raising psychological self-awarness → continued support in permanent housing

2.10. Income, benefits and material security

Housing stability depends partly on financial stability. Access to benefits, social protection, pensions, disability support and other entitlements can therefore become part of an integrated care pathway. The SOLACE-CEE project identified administrative barriers linked to residence and access to local assistance as one example of how formal system design may exclude people experiencing homelessness. For service design, this highlights an important issue. Problems that appear "administrative" may have direct consequences for health and housing. Failure to secure benefits can lead to rent arrears. Lack of identification can block healthcare or social support. Unresolved debt may undermine

housing stability. Integrated care therefore requires the capacity either to address these needs directly or to connect people effectively with organisations that can.

CASE LENS — VPR: sustaining housing requires more than the apartment

For the **VPR family**, movement into permanent housing may shift attention from securing accommodation to sustaining it. Income, benefits, debt, employment and household budgeting can become increasingly important components of stability. This illustrates why housing support, social support and health cannot be neatly divided into sequential interventions.

2.11. Legal support and access to rights

People experiencing homelessness may require assistance with documentation, social entitlements, debt, tenancy rights, family matters, discrimination or other legal issues. These issues can directly affect access to healthcare, housing and social protection. A rights-based integrated-care model should therefore recognise legal support as potentially relevant to health and social stability. Again, integration does not require every organisation to employ legal professionals. It requires that legal needs are identified and that credible pathways exist.

CASE QUESTION — Is the barrier clinical or legal?

A family may appear to have a healthcare-access problem while the underlying barrier is missing documentation, residence requirements, insurance or another administrative/legal issue. Integrated care should be capable of identifying the real source of the barrier and connecting the person with the expertise required to resolve it.

2.12. Employment, participation and meaningful activity

Employment can contribute to income, routine, identity, social relationships and community participation. However, employment should not be treated as the universal or immediate indicator of successful integration. For some people, health stabilisation, housing retention or rebuilding everyday routines may need to precede employment. For others, supported employment may become an important part of recovery. Still others may engage in education, volunteering, peer roles, community activities or family responsibilities.

The PMG therefore deliberately expands social integration beyond employment and includes broader participation, community support and peer involvement. Integrated care should therefore ask:

What form of participation is meaningful and realistic for this person at this point in their pathway?

CASE LENS — Recovery goals change over time

For the **VPR case**, employment may become relevant after housing stability increases. For another person, the immediate goal may be health stabilisation or rebuilding basic daily routines. Person-centred care therefore does not impose the same sequence or outcome on every person.

2.13. Social relationships, community and isolation

Ending homelessness requires more than changing an address. People may move into housing while remaining socially isolated. Long periods of homelessness may weaken family relationships and community connections. A successful housing transition can therefore produce an unexpected challenge: the person is physically safer but more alone. Housing First principles explicitly include social and community integration, which carries this orientation into SOLACE-CEE. Support should consequently consider relationships, community participation, peer support and informal networks as part of longer-term recovery.

CROSS-CUTTING CASE — NMP: housed but not necessarily connected

For the person represented by the **NMP case**, moving into an apartment resolves homelessness but may also remove familiar daily contacts associated with shelters or street environments. Integrated Housing First support therefore considers not only tenancy sustainment and healthcare but also community integration, meaningful activity and relationships.

2.14. Families, parenting and children's needs

When the target group includes families, integrated care must consider the needs of parents and children together. A parent's physical or mental health may affect the whole household. Housing instability may affect child development, school attendance, sleep and healthcare. Financial insecurity may affect nutrition. Trauma and domestic violence may affect both parent and child. The integrated-care response therefore requires a family-sensitive approach that can connect adult care, children's health, housing, social work, psychological support and other relevant services. The SOLACE-CEE explicitly includes **family composition and caring responsibilities** within structured needs assessment. This is not a minor demographic variable. It may fundamentally change the required service architecture.

CASE COMPARISON — Three families, three pathways

The **HESED, Casa Ioana and VPR cases** all involve families but illustrate different service-design challenges. The **HESED case** emphasises community context, inadequate housing and barriers to access. The **Casa Ioana case** emphasises temporary shelter accommodation, safety and trauma-informed family support. The **VPR case** emphasises continuity as the household moves towards and into permanent housing. Their pathways are different precisely because family homelessness is not one standard service category.

2.15. Barriers to healthcare and social services

A recurring mistake in service systems is to equate service availability with service access. A specialist may exist. A clinic may be open. A benefit may technically be available. A referral may have been issued. And yet the person may still not receive the service. Healthcare barriers include stigma, administrative, financial and logistical barriers and emphasises the role of outreach and alternative delivery models. For this manual, barriers should be understood across several dimensions:

- **Physical:** distance, transport, accessibility, opening times.
- **Administrative:** documents, registration, eligibility criteria.
- **Financial:** user fees, medication costs, travel.
- **Organisational:** fragmented referrals, waiting times, complex appointment systems.
- **Informational:** lack of awareness, confusing instructions.
- **Digital:** devices, data connection, digital skills.
- **Relational:** distrust, stigma, discrimination, previous negative experiences.
- **Psychological:** trauma, anxiety, cognitive overload.
- **Practical:** no safe medication storage, no telephone, inability to rest or maintain hygiene.
- **Systemic:** services designed around institutional rules rather than the realities of homelessness.

The design task is therefore not merely to identify whether services exist. It is to identify **where the pathway breaks down**.

CASE COMPARISON — Same health system, different access problems
For the **HCSOM case**, access may break down because of rough sleeping, unstable routines, transport, documentation or distrust. For the **HESED case**, geography, poverty, childcare, discrimination or community isolation may be decisive. For the **Casa Ioana case**, trauma, safety and fear of institutional consequences may influence engagement. For the **Fundacja NMP**, access barriers may continue even after housing because of long-standing mental-health, cognitive or service-navigation difficulties. Equitable integrated care therefore requires different access strategies for different barriers.

2.16. Why fragmented systems fail people with complex needs

The initial SOLACE-CEE needs analysis identified four major structural barriers:

- fragmentation of services;
- absence of targeted health services;
- insufficient outreach;
- insufficient and inconsistent data and advocacy.

These barriers are closely related. Fragmented services make access difficult. Without outreach, people facing the greatest barriers may never enter the system. Without targeted healthcare pathways, treatment remains episodic. Without adequate data, organisations struggle to demonstrate needs, improve services or influence policy. The resulting system can produce a paradox. Each service may fulfil its own task, yet the overall outcome remains poor. A social worker refers a person to healthcare. The healthcare provider treats an acute condition. The hospital discharges the person. The housing service assesses them. The addiction service has a waiting list. Every institution may technically have acted correctly. The person still returns to the street. Integrated care seeks to replace this sequence of isolated institutional outputs with a focus on **shared outcomes and continuity**.

FIVE CASES — One structural problem

The precise fragmentation point may differ across the five cases. For **HCSOM**, the problem may be reaching and connecting a person who moves between the street, shelters and health services. For **NMP**, the challenge may be ensuring that health and psychosocial support continue after permanent housing is secured. For **HESED**, the fragmentation may lie between marginalised communities and mainstream health, social and housing systems. For **Casa Ioana**, family safety, healthcare, social support and housing may be distributed across different institutions. For **VPR**, continuity needs to be preserved across outreach, outpatient care, temporary accommodation and Housing First. The common issue is not the absence of professional expertise. It is the absence of a sufficiently coherent pathway between that expertise and the person who needs it.

3. Foundations of Integrated Health and Social Care

Purpose of this chapter

The first two chapters explain the problem. Chapter 3 defines the response. Integrated Health and Social Care is not simply a larger service package. It represents a different way of organising care: around people and their pathways rather than around institutional boundaries.

The SOLACE-CEE methodology draws on the wider integrated-care movement, Health Care for the Homeless, Housing First, Trauma-Informed Care and the experience of implementation partners. The project proposal describes integrated care **as a paradigm shift in how health and social care are designed, delivered, managed and funded, capable of overcoming fragmentation while responding to the complex needs of vulnerable populations.**

3.1. What Integrated Health and Social Care means

Integrated care is sometimes used loosely to describe almost any cooperation between services. For the PMG, a more demanding understanding is required. Integration means that care is deliberately organised so that people experience **coherent support across health, social and housing domains**. This can involve several levels of integration.

Integration within healthcare

Primary care, mental healthcare, addiction services, nursing and specialist healthcare need functional connections.

Integration between health and social care

Health professionals need ways to respond when housing, income, documentation or social conditions affect treatment. Social professionals need access to clinical expertise when health affects social stability.

Integration with housing

Housing should not operate as a separate final outcome disconnected from healthcare and support.

Integration across settings

Care may need to connect outreach, shelters, clinics, hospitals, respite, community services and permanent housing.

Integration over time

Support should remain coherent as needs and housing circumstances change.

Integration at system level

Funding, legislation, governance, data and institutional relationships must eventually support rather than obstruct integrated practice. The result is not necessarily one organisation. It is one **functional pathway**.

CASE LENS — Five organisational contexts, one methodological test
The five partner cases may be operationally very different. **HCSOM** may combine outreach, shelters and healthcare. **NMP** may organise care around Housing First Values, outreach, psychological support. **HESED** may rely heavily on community-based engagement. **Casa Ioana** may integrate support around families in shelter accommodation. **VPR** may connect outreach, outpatient integrated services and housing-based support.

The test of integration is therefore not whether their organisational structures look alike. It is:

Does the person experience a coherent pathway across the services they need?

3.2. Integration is not the same as co-location

Several professionals working in the same building do not automatically provide integrated care. Similarly, an organisation can operate multiple services while each one maintains separate assessments, records, priorities and responsibilities. Co-location may help because it reduces physical barriers and enables informal communication. But integration requires more. It requires: shared understanding; defined roles; coordination; referral and follow-up; multidisciplinary decision-making where appropriate; continuity; and mechanisms to ensure that somebody remains responsible for the pathway.

An Integration HUB should function as an **accessible entry point into an integrated support system rather than as an isolated service provider**. This sentence should guide the entire manual. The building is not the model. **The pathway is the model.**

CASE QUESTION — What happens after entering the door?
A person may enter a HUB, clinic, shelter or community service successfully. The integration question begins after entry. If another need is identified, can the person actually reach the next service? Is responsibility transferred clearly? Does somebody know whether the referral was completed? Does the care plan remain coherent? The answer to these questions matters more than the number of professionals located under one roof.

3.3. The Four Core Principles of IHSC

The IHSC eLearning consolidates the SOLACE conceptual architecture into four core principles:

1. Whole-Person Integrated Care
2. Low-Barrier and Equitable Access

3. Trust-Based and Trauma-Informed Practice
4. Health and Housing as Rights – System Responsibility

These principles are not four separate interventions. Together, they describe what integrated care should look like from four perspectives: **scope, access, relationship and responsibility**.

3.3.1. Principle 1. Whole-Person Integrated Care

Whole-person care begins with the recognition that a person's physical health, mental and behavioural health, housing situation and social circumstances are interconnected. Needs in one area can create, reinforce or complicate needs in another, and effective support therefore requires an understanding of the person as a whole rather than as a collection of separate problems.

A key dimension of whole-person care is **comprehensiveness — whether the overall system of care is capable of responding to the range of needs experienced by the person.** Integrated care adds a second essential dimension: whether these different forms of care and support are connected and coordinated around the person's individual needs, priorities and circumstances.

Comprehensiveness and integration are related, but they are not the same. A service system may offer many different interventions while still remaining fragmented. Conversely, good coordination cannot compensate for major gaps in essential care. Whole-person integrated care therefore requires both **an appropriate range of services and a coherent pathway connecting them**.

Depending on the population and local context, this wider pathway may include **primary medical care**, including adult primary care, family medicine, internal medicine, paediatrics, obstetric and gynaecological care and access to diagnostic and specialist services; **mental and behavioural health care**, including counselling, psychiatry, psychological support, medication management and family- or child-focused interventions; **substance-use services**, including assessment, harm reduction, treatment and referral; **dental care**; **health promotion and disease prevention**; **medical respite care**; **case management**; **outreach and specialised services**; **pharmaceutical support, transportation and interpretation or translation services**; and **housing-related interventions and support**.

The exact combination will differ between settings and populations. Comprehensiveness does not mean that every organisation must provide every service directly. Some functions may be delivered within the integrated service or Integration HUB, while others may be provided through formal or functional partnerships with mainstream or specialist providers. What matters is whether the **integrated system as a whole can provide or reliably connect the person to the combination of support they need**.

Some functions play a particularly important role in maintaining integration across the pathway.

Case management can connect identification and outreach, assessment, planning, linking to services, monitoring, review and advocacy. It can accompany a person across different settings — from the street or shelter to a clinic, mobile service, hospital, temporary accommodation and permanent housing — and help ensure that multiple interventions form one continuum rather than a series of disconnected contacts.

Outreach extends care beyond fixed service locations. It may be general or specialised, mobile or fixed-site, and should be flexible enough to allow repeated contact, engagement and support according to assessed individual needs. Its role is not simply to identify people but to bring services closer, build engagement and create pathways into wider care.

Medical respite care can address a specific gap for people who are too unwell to recover safely on the street or in unsuitable accommodation but do not require hospitalisation. It may combine medical and nursing care with intensive case management, recovery support and discharge planning, with the aim of preventing people from being discharged back into conditions that undermine recovery.

Housing support is likewise part of the whole-person pathway rather than an external endpoint. Support may be needed before housing is secured, during the transition into housing and after homelessness has formally ended. For some people, health and social needs become easier to address only once stable housing has been established.

Specialised responses may also be necessary where particular needs are significant within the target population, for example HIV or hepatitis care, substance-use services, gender-specific or gender-sensitive healthcare, reproductive health or specialised outreach. These should be integrated into the wider pathway rather than operating as isolated programmes.

The purpose is not to treat every issue simultaneously or to involve every possible professional.

Nor is it to create the largest possible package of services.

The purpose is to ensure that important needs do not become invisible simply because they fall outside the mandate of one profession or organisation, and that the different elements of care contribute to a coherent, person-centred response.

Whole-person care asks:

- What is happening with the person's physical health, and are primary, preventive and specialist healthcare needs being addressed?
- What is happening with their mental and behavioural health?

- Are substance-use needs present, and can the person access appropriate harm reduction, assessment, treatment or specialist support without losing access to other care?
- Are dental, reproductive, diagnostic, pharmaceutical or other healthcare needs being overlooked?
- What is the level of a person's awareness of her health, social and housing condition?
- How endangered is a person's life? Is there an obligation to act regardless of a person's consent?
- What is the person's current housing situation, and how does it affect health, safety and recovery?
- Does the person have a safe and appropriate place to recover following illness or hospitalisation, or is medical respite or another intermediate response needed?
- What social, financial, legal, employment or administrative issues are affecting health and housing stability?
- What relationships, family circumstances and sources of support are present?
- What does the person identify as their main priorities?
- What risks or circumstances could destabilise health, housing or recovery?
- What services and professionals are already involved, and do they share an understanding of the person's needs and priorities?
- Are health, behavioural health, social, housing and other services actually connected around the person, or are they responding to separate parts of the situation independently?
- Where are the most important gaps in care or support?
- Which needs should be addressed directly by the core team, and which require an accessible and reliable pathway to another provider?
- Is there a clear case-management or coordination function ensuring that agreed actions, referrals and follow-up actually happen?
- Does the combination and intensity of support change as the person's needs, priorities and housing situation change?

The answers then inform an **individualised and coordinated care and support pathway**, in which the range and intensity of services reflect the person's needs and priorities rather than the boundaries between organisations or professional disciplines.

Whole-person integrated care therefore does not mean that **everyone receives everything**. It means that **the whole person is considered, relevant needs are not excluded by professional or organisational boundaries, and the necessary forms of care and support are brought together into a coherent response tailored to that person.**

The SOLACE-CEE project places this holistic understanding at the beginning of the methodology and requires health, housing and social needs to be understood and addressed in a coordinated way.

CROSS-CUTTING CASE — HCSOM: medical care alone is not integrated care

For the person represented by the HCSOM case, an untreated chronic condition may require primary healthcare. But the pathway may also need to involve mental-health or substance-use support, harm reduction, benefits, documentation, case coordination, outreach and housing. None of these needs makes healthcare intervention less important. They explain why healthcare must be connected to a wider stabilisation pathway and why outreach and case management may be essential for making that pathway function.

CROSS-CUTTING CASE — VPR: whole-person care continues after housing

When the VPR family enters permanent housing, the need for emergency or temporary accommodation ends. Other priorities may become more visible: healthcare, mental health, parenting, income, tenancy sustainment, employment, social relationships or community integration. The combination and intensity of support can therefore change over time. Whole-person care **follows the person and adapts to changing needs rather than ending when one problem — including homelessness itself — is resolved.**

3.3.2. Principle 2. Low-Barrier and Equitable Access

Integrated care has limited value if people cannot access it. A key dimension of this principle is **accessibility — how, where and when services are provided, and whether people can realistically reach, enter and continue using them in the circumstances in which they live.** For people experiencing homelessness, accessibility often requires **meeting people where they are**. This means more than geographical proximity. Care should, as far as possible, be provided in places, at times and through forms of engagement that people are **able and willing to use**, while maintaining appropriate professional and clinical standards. Low-barrier care therefore adapts services to the realities of homelessness rather than expecting people experiencing homelessness to adapt first to conventional service structures. This may involve a combination of **fixed-site and mobile approaches**. Fixed-site services may include shelter-based clinics, dedicated healthcare facilities, community clinics or other easily accessible locations. Mobile approaches may include street outreach teams, mobile units and outreach linked to shelters, temporary accommodation or other places where people spend time. The purpose is not simply to move services outside a clinic. Outreach and mobile care should create an **entry point into a wider continuum of health, social and housing support**, particularly for people who would otherwise remain outside mainstream systems. Earlier and more accessible care may also help prevent avoidable deterioration, unnecessary emergency-department use and hospitalisation. Accessibility also concerns **time**. Conventional appointment systems may not correspond to the realities of unstable housing, limited communication options, competing survival priorities or unpredictable daily circumstances. Depending on the population, accessible models may therefore

include **walk-in care, same-day appointments, flexible scheduling, appointment reminders, dedicated appointment periods for particular groups, and outreach rounds at different times of day or night**. Accessibility should also be examined **horizontally and vertically**.

Horizontal accessibility concerns whether people can move across the wider community network — for example between healthcare, social services, housing, shelters, addiction services, justice-related services and other forms of support.

Vertical accessibility concerns whether people can move through different levels of care within a system — from outreach and primary care to diagnostics, specialist care, hospital treatment, medical respite and follow-up.

In both directions, the person should not be expected to coordinate a complex system alone.

A **no-wrong-door approach** means that wherever a person first enters the system, that point of contact helps connect them with the appropriate next step rather than simply redirecting them elsewhere.

Access should also not depend unnecessarily on financial or administrative capacity. Services should examine whether inability to pay, lack of personal identification, absence of a permanent address, registration requirements or other administrative conditions are preventing people from receiving essential care, and remove such barriers wherever this is legally and clinically possible.

Low-barrier care therefore examines the service from the user's perspective:

- Can the person physically reach the service?
- Are services also available **where people experiencing homelessness actually are** — through outreach teams, mobile units, shelter-based clinics, on-site services or other community settings?
- Are people offered care in ways and places they are realistically able and willing to use?
- Are outreach and mobile services reaching people who would otherwise remain outside mainstream healthcare?
- Does outreach connect people with the wider health, social and housing system rather than functioning as an isolated intervention?
- Are services available at times that correspond to people's actual circumstances?
- Are walk-in care, same-day appointments or flexible scheduling available where appropriate?
- Are appointment reminders or other forms of active follow-up used when they can support engagement?
- Would outreach at different times of day or night improve access for the target population?

- Are documents, identification, registration requirements or administrative procedures creating barriers that are not genuinely necessary?
- Can essential services be accessed regardless of the person's ability to pay?
- Does the appointment model reflect the realities of unstable living?
- Is the service physically and practically accessible for people with disabilities, mobility limitations or significant health problems?
- Are transport barriers identified and addressed where possible?
- Are language, literacy, communication and interpretation needs addressed?
- Is digital exclusion creating a new barrier to otherwise accessible services?
- Is the environment safe, welcoming, respectful and non-stigmatising?
- Can somebody enter the integrated system through different points — for example outreach, a clinic, shelter, hospital, social worker, Housing First programme or community service?
- Is there a **no-wrong-door approach**, so that the first service contacted helps the person reach the support they need?
- Can professionals actively support navigation and warm handovers rather than relying only on passive signposting?
- Can a person receive one form of support without first agreeing to every other intervention?
- Is access conditional on abstinence, treatment adherence, behavioural compliance or being considered "ready"?
- If a person misses an appointment or contact is interrupted, is there a realistic mechanism for follow-up and re-engagement rather than automatic discharge?
- Can people move effectively from outreach and primary care to diagnostics, specialist services, hospital care, medical respite and back to community-based care?
- Can they also move across healthcare, social services, housing and other relevant sectors without repeatedly starting again?
- Is continuity maintained when the person moves between the street, shelter, hospital, temporary accommodation and permanent housing?
- Are patterns of emergency-department use or repeated hospitalisation examined as possible indicators that earlier or more accessible community-based care is missing?

Low-barrier access does not mean low-quality care. It means **removing barriers that are not clinically, ethically or legally necessary while maintaining the same expectation of professional, evidence-informed and high-quality care.** Nor does low-barrier care mean that every service must be available everywhere and at all times. It means designing a **flexible combination of access points and pathways** appropriate to the needs and circumstances of the population. Equity adds another dimension. Providing everyone with the same appointment system, the same information and the same level of navigation support may appear equal, but it will not produce equal access when people face very different barriers. Equitable access therefore means **adapting the route and intensity of support so that people facing greater barriers have a realistic opportunity to reach,**

use and benefit from care. In practical terms, accessibility is strongest when people can **reach care, enter care, move across and within systems, remain connected to care, and re-enter care when contact has been interrupted**. The SOLACE-CEE project reflects this principle through its emphasis on immediate and low-threshold access to health and social support, flexible and individualised care, outreach and mobile approaches, and continuity across different housing and service settings.

Facilitating accessibility has its limits. At some point some people will graduate from specialist support programs e.g. specialist clinics for the homeless or housing programs to more independent living in regular apartments in the local communities as they are with tier local mainstream support system. Most probably, the general health, social and housing support that former users of specialist low barrier services will have to turn to will present low accessability. The former users will have to be self-competent and able to approach and remove all the barriers that in the past were removed by others e.g. directors of specialised health clinics for the homeless. The delicate line between barrier-removing actions of the service provider and independent actions of the user has to be taken into account from the very beginning of service design and support process.

CASE COMPARISON — HCSOM and HESED: equal availability, unequal access

For the person represented by **HCSOM**, the principal barriers may include sleeping rough, unpredictable daily circumstances, distance from a clinic, lack of identification, difficulty keeping appointments, previous negative experiences with institutions or limited ability to navigate referrals. A standard appointment offered several weeks in advance may therefore be formally available but functionally inaccessible. Outreach, repeated contact, flexible timing, active navigation or a same-day route into care may be required. For the **HESED family**, the barriers may be different: geographic isolation, transport costs, childcare responsibilities, poverty, administrative status, discrimination, language or distrust of mainstream institutions.

The appropriate response might therefore involve community-based engagement, support with navigation, adapted appointment arrangements, transport or stronger links between community and mainstream services. Providing both with exactly the same service would be **equal**. It would not necessarily be **equitable**.

The methodological question is therefore not only:

Is the service available?

but:

Can this person realistically reach it, use it and remain connected to it?

3.3.3. Principle 3. Trust-Based and Trauma-Informed Practice

Integrated care is relational. A technically strong and clinically appropriate service can still fail if people do not trust it enough to use it, return to it or disclose what they need. A key dimension of this principle is **attitude — who provides services, how professionals understand the people they serve, and how that understanding shapes everyday interactions, clinical decisions and organisational practice.** Professionals working with people experiencing homelessness should understand that health needs rarely exist in isolation. Physical illness may interact with mental health, substance use, trauma, housing instability, poverty, family relationships, employment, legal problems and repeated experiences of exclusion. This complexity should shape professional responses rather than lead to people being labelled as "difficult", "non-compliant" or "unmotivated".

The PMG therefore places **relationship-based engagement, consistency, respect and trust** at the centre of integrated care. Trust cannot be demanded. It is built through repeated experience. It develops when people experience services as predictable, respectful, competent and non-judgemental; when professionals do what they say they will do; when people are not abandoned after missed appointments or relapse; and when their priorities and choices are taken seriously.

Person-centred and team-based care

Trust-based practice is strengthened by **person-centred and team-based models of care**. Multidisciplinary teams can help overcome fragmentation by bringing together the perspectives needed to understand complex and interacting needs. Depending on the population and context, teams may include physicians, nurses, psychologists, psychiatrists, social workers, case managers, counsellors, outreach workers, addiction specialists, housing workers, peer workers, support staff and other relevant professionals or para-professionals. The purpose is not simply to place several professionals around the same person. A multidisciplinary team should develop a **shared understanding of the person's situation, priorities and goals**, coordinate responsibilities and contribute to one coherent care and support pathway. Medical care, mental and behavioural health, substance-use support, housing, income, employment, family relationships and other domains should not become separate professional agendas competing for priority. Person-centred care asks instead:

What matters to this person now, what support is needed, and how can the team organise itself around those priorities?

Trauma-Informed Care

Trauma-Informed Care strengthens this relational foundation. People experiencing homelessness may have experienced violence, abuse, loss, institutionalisation, family separation, repeated displacement, discrimination, coercive systems or prolonged insecurity. Homelessness itself can also be traumatic. Services should therefore be

organised in ways that reduce the risk of reproducing experiences of powerlessness, humiliation or loss of control. **Safety, transparency, choice, collaboration and empowerment should shape routine practice.** The relationship should reduce rather than reinforce shame. Professional boundaries should be clear but not punitive. People should know what is happening and why. Consent should be meaningful. Choices should be offered wherever realistic. Behaviour should be interpreted in context. The organisation should recognise that anger, withdrawal, missed appointments, reluctance to disclose information, difficulty making decisions or inconsistent engagement may have many explanations, including trauma, fear, cognitive overload, substance use, previous negative experiences and survival priorities. Understanding behaviour in context does not mean removing professional boundaries or accepting unsafe behaviour. It means responding in ways that maintain **safety, dignity and the possibility of continued engagement**.

Evidence-informed relational practice

Trust-based care should also draw on **evidence-informed and evidence-based practices** that recognise autonomy, readiness and the complexity of behavioural change. Depending on individual needs and context, these may include:

- Trauma-Informed Care;
- harm reduction;
- motivational interviewing;
- solution focused therapy;
- stages-of-change approaches;
- recovery-oriented practice;
- person-centred care;
- and other evidence-informed approaches supporting engagement and behavioural change.

These approaches share an important principle: change cannot simply be imposed by the professional. Recovery cannot be demanded. The role of the service is to create conditions in which people can engage, make informed choices, reduce harm and work towards goals that are meaningful to them. Evidence-informed care should therefore consider **multiple outcomes**, rather than defining success through a single clinical indicator. Relevant outcomes may include physical health, mental health, housing stability, safety, engagement, quality of life, autonomy, social participation, recovery and continuity of care.

Relationships across services

Trust can also be lost when the person moves from one organisation to another. An integrated model therefore requires **community partnerships and reliable referral**

relationships extending beyond the immediate multidisciplinary team. Depending on local context, this network may include hospitals and inpatient services, primary and specialist healthcare, mental-health and substance-use services, social services, housing providers, shelters, justice or correctional services, employment and income-support services, social-security systems and other community or safety-net providers. Referral alone is not integration. Where people face significant barriers, cooperation should support **warm handovers, active navigation, appropriate information exchange, follow-up and continuity**. A person should not have to rebuild trust with the system from the beginning every time responsibility moves from one service to another.

Participation and lived experience

Trust also requires a change in the relationship between services and the people who use them. People with lived experience should be involved not only as recipients of care but, where feasible, in **assessment of needs, development and monitoring of individual care plans, feedback on programmes and services, peer support, advocacy, service improvement and service design**. Structured mechanisms may include peer roles, service-user groups, advisory bodies or Consumer Advisory Boards. Participation should be meaningful rather than symbolic. The question is not simply whether people were asked for their opinion. It is whether their experience can **influence decisions**. At an individual level, this means shared decision-making and care plans reflecting the person's own priorities. At programme level, it means using lived experience to identify and remove barriers, unintended consequences and opportunities for improvement that may not be visible to professionals.

Trust and quality

Trust-based care should never be confused with informal or lower-quality care. A respectful relationship is not a substitute for clinical competence. At the same time, technically correct care is not sufficient if people do not feel safe enough to engage with it. **Relational quality and professional quality must reinforce each other.** Organisations should therefore combine trust-based practice with **systematic quality assessment, outcomes measurement and continuous improvement**. Depending on the service, this may include:

- monitoring engagement and continuity;
- measuring relevant health and social outcomes;
- reviewing clinical quality and adherence to appropriate protocols;
- analysing referrals and follow-up;
- collecting and analysing service data;
- using electronic health records or other appropriate information systems;
- examining complaints, disengagement and adverse events;
- obtaining feedback from people using services;
- and translating findings into service improvement.

Quality improvement should ask not only whether an intervention was delivered correctly, but also whether people could engage with it, whether continuity was maintained and whether the service produced outcomes meaningful to the person.

Trust-based and trauma-informed practice therefore asks:

- Do professionals understand the comprehensive and interacting needs of people experiencing homelessness?
- Does the person experience professionals as respectful, consistent, competent and non-judgemental?
- Is the support predictable enough to bring constancy to people's lives?
- Are people treated as partners in care rather than passive recipients?
- Are care decisions made **with** the person rather than **for** the person wherever possible?
- Does the team share an understanding of the person's priorities, or are different professionals pursuing separate agendas?
- Are professional responsibilities coordinated across disciplines?
- Does practice recognise the possible effects of trauma, stigma, institutionalisation and previous exclusion?
- Are safety, transparency, choice, collaboration and empowerment visible in routine interactions?
- Is behaviour interpreted in context rather than immediately labelled as non-compliance?
- Are evidence-informed approaches such as Trauma-Informed Care, harm reduction and motivational interviewing used appropriately?
- Can the relationship survive missed appointments, relapse, interrupted contact or periods of disengagement?
- Are referrals supported by relationships, navigation and follow-up rather than passive signposting?
- Are there clear rules for obtaining people's consent for certain actions e.g. data sharing across services?
- Is trust maintained as the person moves between professionals, organisations and housing situations?
- Can people with lived experience meaningfully influence the care plan created for them?
- Can they contribute to the design, management, evaluation and improvement of services?
- Are peer roles or other forms of lived-experience participation supported where appropriate?
- Does the organisation learn from complaints, disengagement and negative experiences rather than treating them only as individual failures?
- Are professional competence, relational quality and outcomes assessed together?
- Do data and feedback lead to changes in practice?

In this sense, **attitude is not simply an individual personality characteristic of a good professional. It is an organisational characteristic.** It is reflected in **who is recruited, how professionals are trained, how multidisciplinary teams work, how staff are supervised, how people with lived experience participate, how services respond to complexity and setbacks, how partnerships operate, and whether the organisation systematically learns from the people it serves.** A trust-based and trauma-informed organisation therefore does more than employ compassionate professionals. It creates structures, procedures and a professional culture that make **respect, safety, competence, continuity, participation and trust reproducible features of care rather than qualities dependent on individual staff members.**

CROSS-CUTTING CASE — Casa Ioana: the same assessment can feel very different

A mother represented by the **Casa Ioana case** may be asked by several professionals to explain her family's circumstances, health needs and experiences of violence or homelessness. From the organisational perspective, each professional may be collecting information necessary to perform their role. From her perspective, the process may feel repetitive, intrusive and unpredictable, require repeated disclosure of traumatic experiences and reinforce the feeling that she has little control over what happens next. A trauma-informed response does not necessarily remove the need for assessment. It asks how the same necessary information can be obtained and used with **greater safety, transparency, coordination and choice**. *Can information already provided be shared appropriately, with consent, rather than repeatedly requested? Does she know why questions are being asked and what will happen with the information? Can she influence the pace and priorities of the assessment? Do professionals coordinate their actions around one shared plan? Does the process preserve dignity and agency?* The difference may therefore lie not in **what** the service needs to know, but in **how the organisation obtains, shares and acts on that information**.

3.3.4. Principle 4. Health and Housing as Rights – System Responsibility

The fourth principle changes where responsibility is located. If health and housing are rights, failure to access them cannot automatically be framed as an individual's failure. The system has responsibilities too. A key dimension of this principle is **philosophy — why integrated care is provided and what ultimate purpose it is intended to serve.** The goal is not simply to manage illness, crisis or homelessness more effectively. It is to support people to improve their health, stabilise their lives, obtain and sustain housing, and ultimately move out of homelessness. This philosophy places particular emphasis on the understanding that **housing is healthcare**. Safe, stable and adequate housing creates the conditions in which recovery, disease management, mental health, social participation and longer-term wellbeing become more achievable. Health and social support should therefore contribute to pathways towards permanent housing rather than become increasingly sophisticated systems for managing people within homelessness. This

requires organisations to examine: eligibility; gatekeeping; institutional fragmentation; discrimination; availability, accessibility and adequacy of housing; continuity of care and support; service design; whether housing or healthcare is conditional on treatment compliance, abstinence or perceived "readiness"; whether people remain trapped in temporary or crisis responses despite needing permanent housing; and participation of people with lived experience in individual decisions, service development, monitoring and system improvement.

The Health Care for the Homeless model underpinning SOLACE is described in the supporting research not merely as a service model but as a **social justice movement rather than charity**, with housing understood as healthcare and people with lived experience involved in service development and monitoring. This rights-based orientation distinguishes integrated care from benevolent service provision. People are not receiving favours. They are accessing support necessary to realise health, dignity and housing stability. A rights-based philosophy also means recognising that recurring barriers experienced by individuals frequently reflect failures in systems rather than isolated personal circumstances. If people repeatedly cannot register for healthcare, are discharged from hospital without a safe place to recover, lose support when they move into housing, or remain excluded from permanent housing because of complex needs, these patterns should become questions for organisational and system-level action.

For this reason, **advocacy is part of integrated care rather than an activity entirely separate from service delivery**. Organisations can use evidence from practice to advocate at local, regional and national levels for improved access to healthcare, adequate and affordable housing, Housing First and housing-led responses, stronger continuity between systems, and policies that reduce rather than reproduce exclusion.

Advocacy may therefore ask:

- ➔ Do existing healthcare rules create avoidable barriers for people experiencing homelessness?
- ➔ Are adequate housing options available for people with high or complex support needs?
- ➔ Do funding and reimbursement systems support continuity and multidisciplinary care?
- ➔ Do hospital, health, social and housing systems share responsibility for transitions?
- ➔ Are people required to prove "readiness" before they can access housing or essential support?
- ➔ Are recurring service failures documented and communicated to decision-makers?
- ➔ Are organisations addressing the structural causes revealed through everyday practice, rather than repeatedly managing their consequences?
- ➔ Are people with lived experience able to influence advocacy priorities and proposed solutions?

The ultimate measure of this philosophy is not simply whether services become more efficient. It is whether people are better able to **get well, stabilise their lives, secure and sustain permanent housing, and leave homelessness behind**. In this sense, integrated health and social care is both a service response and a **human-rights and social-justice approach**. Its purpose is not only to improve individual interventions, but to contribute to systems in which health and housing are treated as rights, responsibility is shared across institutions, and fewer people are left to navigate homelessness and fragmented services alone.

FIVE CASES — FIVE SYSTEM QUESTIONS

HCSOM — Hungary

Why should a person sleeping rough be expected to navigate several disconnected institutions in order to receive interconnected health and social support?

Fundacja NMP — Poland

Why should access to permanent housing depend on resolving mental-health, substance-use or other support needs first?

HESED — Bulgaria

Why should living in an informal settlement or severely inadequate housing determine whether a family can effectively access healthcare?

Casa Ioana — Romania

Why should a family repeatedly disclose difficult or traumatic experiences because services do not coordinate?

VPR — Slovakia

Why should established health and social support disappear simply because a family moves from homelessness or temporary accommodation into permanent housing?

These are not only questions about individual practice. They are questions about **how responsibility is organised across systems**.

From Core Principles to Operating Principles

The four core principles above provide the overarching methodological foundation of the SOLACE-CEE approach: they define what should remain true across different populations, organisational models and national contexts. The sections that follow translate this foundation into a set of **operating principles, practice approaches and enabling mechanisms** through which integrated care can be organised and experienced in practice. Concepts such as person-centred care, Housing First values, recovery orientation, harm reduction and Trauma-Informed Care help define **how support should be provided**, while outreach, multidisciplinary working, case management, continuity of care, participation, digital health and data-informed learning describe key mechanisms through which those

principles can be operationalised. These elements are deliberately interconnected and should not be understood as separate or additional core principles, nor as a checklist that every organisation must reproduce in the same form. Rather, they show how the four core principles can be translated into coherent practice while allowing the specific organisational model to be adapted to local needs, resources and system conditions.

3.4. Person-centred care

Person-centred care is a central operating principle. Person is an active participant whose priorities, capacities, circumstances and preferences inform objectives and interventions. The Backbone specifically identifies dignity, autonomy, informed choice, shared decision-making, recovery orientation, continuity and flexible individualised interventions. This has consequences for professional practice. A standardised assessment can identify needs, but the support plan cannot simply be generated from professional scoring. The person's own priorities matter. One person may want housing before addressing substance use. Another may prioritise physical pain. Another may want to restore contact with family. A parent may prioritise children. Person-centred care does not remove professional responsibility or safeguarding obligations. It changes the nature of decision-making. Professionals provide expertise. The person provides expertise about their own life. Integrated care should use both.

CASE LENS — The same service goals should not be imposed on everyone

The **HCSOM case** may initially prioritise physical safety, healthcare or housing. The NMP case may prioritise maintaining a tenancy, mental-health recovery or social relationships. The **HESED family** may prioritise children's health or housing conditions. The **Casa Ioana family** may prioritise safety. The **VPR family** may prioritise permanent housing and stability. Person-centred care starts with these priorities rather than assuming that the professional's preferred sequence is automatically the person's pathway.

3.5. Housing First values as a methodological foundation

The PMG deliberately uses the formulation **Housing First values and principles**, because these principles can inform integrated services even when a programme is not itself a formal Housing First programme. These values include: housing as a fundamental right; choice and self-determination; separation of housing and support; recovery orientation; harm reduction; active engagement without coercion; person-centred planning; social and community integration. The key methodological shift is from **housing readiness** to **housing as a platform for recovery**. Traditional staircase models assume progression towards housing after demonstrating readiness. Housing First reverses the sequence. Stable housing creates the conditions in which treatment, recovery, relationships and participation can become more achievable. This does not mean that every person needs Housing First. It means that the PMG rejects systems where people with the greatest support needs are excluded from housing precisely because those needs are complex.

CROSS-CUTTING CASE — NMP: reversing the sequence

The NMP case makes this difference visible. A staircase approach may expect the person to first demonstrate sufficient stability and treatment engagement before permanent housing is considered. Housing First Values reverse the direction:

Permanent housing

→ continued health, mental-health and social support

→ recovery, stability and community integration.

The core principle is therefore not "housing instead of support". It is **housing without preconditions, with support continuing according to needs and goals of the participants**.

3.6. Trauma-Informed Care as a cross-cutting operating principle

TIC should not appear only in the mental-health section of an integrated service. It should influence: reception; assessment; clinical encounters; housing support; outreach; referrals; crisis management; communication; data collection; team culture; supervision; leadership; and organisational policies.

This is why Level 2 will later contain a dedicated TIC implementation chapter while simultaneously embedding TIC principles across service design, MDT work, pathways and digital care.

CASE LENS — From trauma-aware worker to trauma-informed pathway

The **Casa Ioana case** will return in Level 2 not only when discussing psychological support but when examining reception, assessment, communication, safety, referrals and organisational procedures. This reflects an important distinction:

TIC is not one service within the pathway. It is a quality of the pathway itself.

3.7. Recovery-oriented practice

Recovery orientation shifts attention away from maintaining people indefinitely within services and towards enabling a meaningful, self-directed life. Recovery is individual. For one person, it may mean symptom stabilisation. For another, maintaining housing. For another, reducing substance-related harm. For another, reconnecting with family or entering employment. For somebody with severe and enduring disability, recovery may mean increased safety, autonomy and quality of life rather than complete independence. The role of integrated care is therefore not to define one universal endpoint. It is to support a pathway towards greater stability, agency and participation.

CASE LENS — Five people, different definitions of progress

Progress in the **HCSOM case** might initially mean greater engagement and safer management of health. In the **NMP case**, it may include maintaining housing and rebuilding community participation. For the **HESED family**, improved access to healthcare and safer living conditions may be central. For the **Casa Ioana family**, safety and movement towards stable housing may define progress. For **VPR**, the pathway may involve housing retention, family stability and longer-term social integration. Recovery orientation allows these goals to differ.

3.8. Harm reduction

Harm reduction is closely connected to Housing First and trauma-informed practice. It accepts the reality that change may be gradual. Services aim to reduce preventable harm while maintaining engagement. This is particularly relevant to substance use but also reflects a wider methodological stance: support should not be withheld because somebody has not achieved an ideal level of behavioural change. Harm reduction allows services to remain connected during periods of relapse, ambivalence or instability. This continuity can itself be protective.

CASE LENS — Maintaining the relationship

For a person represented by **HCSOM** or **NMP** who uses substances, integrated care does not disappear when behaviour does not follow the professional ideal. The system remains engaged, seeks to reduce harm and continues offering healthcare, housing and social support.

3.9. Outreach and "meeting people where they are"

The Health Care for the Homeless tradition informing SOLACE-CEE emphasises **meeting patients where they are**—both literally and figuratively. Its components include fixed clinics, shelter-based services, street outreach, mobile care, flexible appointments, no-wrong-door approaches and care regardless of ability to pay. The SOLACE-CEE project adopts this logic directly. Outreach should occur where people live or seek support and should aim primarily at building trust, engaging people who do not access mainstream services and connecting them with broader care. Outreach is therefore not simply a separate programme. It is an **access strategy within integrated care**.

CROSS-CUTTING CASE — HCSOM: the service moves first

For someone sleeping rough, insisting that healthcare starts only when the person arrives at the clinic places the entire access burden on them. The **HCSOM case** illustrates the opposite principle: **The service can move towards the person first**, build a relationship and gradually connect them with wider healthcare and social support.

3.10. Prevention, outreach, outpatient care and specialist care as a continuum

The PMG explicitly recommends combining different levels of engagement: preventive services; outreach; outpatient and community services; referral and specialist services. This allows care to respond to different stages of need. A person who does not yet trust a clinic may initially engage through outreach. A person with stable housing may access outpatient follow-up. A chronic condition may require specialist consultation. A deterioration may require hospital care. After discharge, community follow-up becomes necessary again. Integration therefore requires movement **both horizontally across sectors and vertically across levels of healthcare**. The underlying IHSC research similarly describes accessible integrated care as both horizontally coordinated across community sectors and vertically linked across healthcare levels

CASE PATHWAY — One person may use several levels of care
The **HCSOM case** may move through:

outreach → primary care → specialist or hospital care → community follow-up.

The **NMP case** may move from:

Housing First support → primary care → mental-health specialist → housing-based follow-up.

Integrated care means that these levels remain connected rather than functioning as separate episodes.

3.11. Integration HUBs: gateway, not destination

SOLACE-CEE introduced Integration HUBs or equivalent coordinated structures as practical mechanisms for bringing services together. HUB may provide or coordinate primary healthcare, mental healthcare, psychological support, social work, housing support, addiction services, employment or financial counselling where relevant, outreach, specialist referrals and digital health. The key word is **coordinate**. No single organisation is expected to deliver every specialist intervention directly. A mature HUB is therefore not defined by the number of rooms or professionals it employs. Its effectiveness depends on whether it functions as an accessible entry point into a broader system. A small service with strong pathways may be more integrated than a large multidisciplinary centre whose professionals work in parallel. This distinction will guide service-design decisions in Level 2.

CASE LENS — Different organisational forms, same gateway function
For **HCSOM**, the gateway may connect established shelter, outreach and health infrastructure. For **HESED**, it may be strongly community-based. For **VPR**, it may connect outreach, outpatient integrated services and housing support. The physical structure can

differ. The methodological function is the same: **the person enters one part of the system and can reach the rest of the pathway from there.**

3.12. Multidisciplinary teams and shared responsibility

Integrated care requires different expertise. The PMG identifies potential roles including social workers, GPs, nurses, psychiatrists, psychologists, addiction specialists, outreach workers, housing specialists, employment specialists and peer workers. Again, the methodology does not prescribe that all must be employees of one organisation. The essential requirement is **effective coordinated cooperation**. Multidisciplinary work becomes integrated when roles are clear, information flows appropriately, teams communicate and somebody holds responsibility for follow-up. This distinction between professional diversity and actual integration is important. A room full of specialists is not yet an MDT. **An MDT is a mechanism for shared understanding and coordinated action.**

CASE LENS — The MDT depends on the case

The **HCSOM case** may require stronger input from outreach, primary care, mental health and addiction services. The **Casa Ioana case** may require social work, psychological support, family and housing expertise. The **VPR case** may require healthcare, housing, social work and employment or community-integration support over time. The target population therefore determines the expertise that needs to be connected.

3.13. Case management and navigation

Case management plays an important role where people interact with multiple systems. Its function is not to replace all professionals. It provides continuity and helps the person move through the care pathway. Depending on target population and complexity, services may use different intensities of case management. The IHSC eLearning includes the distinction between Intensive Case Management and Assertive Community Treatment as examples of how support intensity and team configuration can vary. The appropriate model should therefore emerge from needs assessment rather than organisational habit.

CASE QUESTION — Who knows what happened next?

Across all five cases, referral without navigation can reproduce fragmentation. Case management becomes particularly important when the person or family interacts with several health, social and housing systems simultaneously. Its value lies not in adding another professional to the pathway but in helping ensure that the pathway remains coherent.

3.14. Triage without gatekeeping

The PMG includes triage as part of integrated service architecture. Triage should identify urgent medical conditions, acute mental-health needs, addiction risks, safeguarding concerns, immediate housing risks and situations requiring specialist intervention. But

triage must be distinguished from gatekeeping. The aim is to determine **what needs attention first**, not **who deserves access**. A transparent and proportionate triage system supports safety while preserving the low-barrier orientation of the service.

CASE LENS — Different urgency, same right to access
A person represented by **HCSOM** may present with an urgent untreated physical-health need. The **Casa Ioana family** may have an immediate safety or safeguarding concern. The **HESED family** may present with a non-urgent but persistent health and housing problem. Triage determines priority and response. It should not become a mechanism through which people with complex needs are labelled "too difficult" for the service.

3.15. Continuity of care

Continuity is one of the strongest threads running through SOLACE-CEE. Integrated care should remain available when a person's housing situation changes. The IHSC principles explicitly require continuity between homelessness, temporary accommodation and stable housing and states that moving into housing should not result in loss of established therapeutic or social relationships. This may require: follow-up after hospital discharge; support during housing transition; ongoing healthcare after leaving shelter; coordination between outreach and clinic teams; information transfer; and proactive re-engagement after missed contact. Continuity is therefore not one service. It is a quality of the entire pathway.

CROSS-CUTTING CASE — VPR: the address changes, the pathway continues
The **VPR case** will act as the principal longitudinal illustration of continuity throughout the PMG:

severe housing exclusion → outreach → temporary accommodation → integrated healthcare and social support → permanent housing → continued support → stabilisation.

At each stage, needs and service intensity may change. Continuity does not mean providing the same intervention forever. It means ensuring that support changes **with** the person's circumstances rather than disappearing because of them.

3.16. Digital health and telemedicine as enabling components

Telemedicine and remote monitoring form one of the SOLACE innovation components, but the PMG is clear that they should be used **where they add value** and should complement rather than replace face-to-face services. Their conceptual role within IHSC is to reduce specific barriers. They may help provide: specialist consultation; mental healthcare; chronic disease follow-up; remote monitoring; professional consultation; and continuity where geography or capacity limits face-to-face access. But technology alone cannot produce integration. A teleconsultation becomes integrated care only when: the person is prepared and supported; clinical roles are clear; recommendations enter the care plan;

follow-up occurs; and local teams can act on the outcome. The Telemedicine eLearning developed within SOLACE reinforces precisely this point: remote care functions best as part of a human-centred, team-based care model rather than as a technology project.

CASE LENS — HCSOM: digital health inside a real care pathway

The **HCSOM case** provides a natural context for later exploration of telemedicine, telepsychiatry and remote monitoring. The relevant learning is not that every homelessness service needs telemedicine. It is that digital care may improve access **when it is connected to local professionals, follow-up and an existing human relationship**.

3.17. Participation and lived experience

Person-centred care should extend beyond individual consultations. The SOLACE-CEE project includes a participative approach in which people experiencing homelessness are actively involved in service design and can influence the services they use. The broader HCH model used as a foundation also emphasises consumer participation in needs assessment, service planning, monitoring, advocacy and peer support. This reflects an important distinction. Professionals have expertise in care. Managers have expertise in systems. Researchers have expertise in evidence. People who use services have expertise in **how those systems are actually experienced**. A credible integrated-care model requires all four forms of knowledge.

FIVE CASES — What professionals cannot see alone

Each case can reveal implementation barriers that may remain invisible in organisational data. The **HCSOM case** may reveal why conventional appointments fail. The **NMP case** may reveal what support remains important after housing. The **HESED family** may reveal barriers associated with community context and discrimination. The **Casa Ioana family** may reveal how assessment and procedures are experienced through a trauma lens. The **VPR family** may reveal where continuity breaks during housing transitions. Lived experience therefore contributes evidence that professional observation alone cannot provide.

3.18. Data-informed and evidence-oriented practice

Data is not limited to evaluation at the end of implementation. The PMG positions data much earlier. Needs assessment findings should shape: the services offered; team composition; location; access; outreach; referrals; digital tools; training; and partnerships. This produces a continuous learning model:

data → design → implementation → monitoring → learning → adaptation.

The same principle prevents a common implementation error: adopting an attractive international model without first asking whether it responds to the local population. Evidence-based practice does not mean importing a model unchanged. It means combining

evidence about what works with evidence about **where, for whom and under what conditions it must work locally**.

CASE LENS — Different cases should produce different service designs
If **HCSOM**, **HESED**, **Casa Ioana**, **NMP** and **VPR** performed identical needs assessments and all produced identical service models, this would raise an important methodological question. Their populations, housing situations and local systems differ. The purpose of data is therefore not to confirm a pre-selected model. It is to help determine **which version of integrated care is appropriate locally**.

3.19. Professional capacity and a shared language

Integrated care asks professionals to understand more than their own disciplinary task. A doctor does not need to become a housing specialist, but should understand why housing affects treatment. A social worker does not need to make clinical decisions, but should recognise health risks and know the healthcare pathway. A housing worker should understand how trauma or mental illness may affect tenancy support. A telemedicine assistant needs clear boundaries between facilitation and clinical responsibility. The methodology therefore requires capacity building across homelessness, health inequalities, IHSC, Housing First, TIC, mental health, substance use, outreach, multidisciplinary cooperation, digital health, communication, ethics and data protection. Shared knowledge creates shared language. Shared language makes coordination easier.

CASE QUESTION — What does each professional need to understand?
The Casa Ioana case may require healthcare professionals to understand trauma and family safety. The HESED case may require clinicians to understand the health consequences of housing conditions and structural exclusion. The NMP case may require housing workers to recognise continuing mental-health or health needs after tenancy begins. Integrated care therefore depends not only on adding professions but on increasing mutual understanding between them.

3.20. Integrated care as a learning system

The PMG does not present the methodology as something implemented once and then fixed. It explicitly describes SOLACE-CEE as an evolving framework and requires continuous learning, monitoring, evaluation, feedback and adaptation. This matters conceptually because complex systems cannot be designed perfectly in advance. An organisation may discover that: the target population differs from expectations; one service has low uptake; a referral pathway does not work; staff require different skills; digital tools are inaccessible; a partner cannot provide the expected capacity; or a new population emerges. A mature methodology must be able to learn from these findings. The core cycle is:

Assess → Design → Implement → Monitor → Learn → Adapt → Scale.

This principle links Level 1 directly to the later implementation and system chapters.

CASES AS A LEARNING DEVICE

The five cross-cutting cases will therefore not remain static throughout the PMG. As implementation develops, each case can reveal different questions. A service solution that appears appropriate during initial design may need adaptation when the person's actual pathway is followed. The cases allow the reader to repeatedly ask:

What happened next?

That is also the question a learning system should continuously ask of its own implementation.

3.21. From service integration to system responsibility

Integrated care ultimately exposes structural questions. *Why is access difficult? Why do people fall between health and social care? Why does support disappear after housing? Why can hospitals discharge into homelessness? Why is preventive care unavailable? Why do services depend on short-term grants? Why are relevant datasets disconnected? Why do professional roles or regulations prevent coordination?* These questions cannot all be solved at team level. The PMG therefore ends not with service operation but with sustainability, replication, evidence and policy change. Integrated practice should eventually contribute to institutionalisation, sustainable financing, mainstream integration, policy support and broader changes in how homelessness and health inequalities are addressed. This provides the bridge to Level 3 of the PMG.

The long-term objective is not to build a permanent parallel system for people experiencing homelessness. It is to use targeted integrated approaches to **correct failures of access, demonstrate effective models, connect people with mainstream systems where possible and influence those systems to become more equitable and responsive**.

FIVE CASES — From individual experience to system evidence

The five cases also help illustrate how a recurring individual problem becomes a system question. If the **HCSOM case** repeatedly encounters inaccessible mainstream healthcare, accessibility becomes a system issue. If the **NMP case** demonstrates that support remains necessary after permanent housing, financing and service eligibility after homelessness become system issues. If the **HESED family** repeatedly encounters geographic, administrative or discriminatory barriers, unequal access becomes a system issue. If the **Casa Ioana family** must repeatedly navigate disconnected safety, health and housing services, cross-sector coordination becomes a system issue. If the **VPR family** risks losing established support during the transition into housing, continuity becomes a system issue. Level 3 will return to precisely these questions through partnerships, financing, regulation, evidence, advocacy and scaling.

3.22. Level 1 Summary: Bringing the Concepts Together

The three chapters of Level 1 establish the conceptual logic that will guide every practical decision later in the manual. Homelessness is diverse and dynamic. It cannot be reduced to rough sleeping or explained entirely through individual behaviour. People move through housing pathways, and these pathways are shaped by structural conditions, institutions, health, relationships and personal circumstances. Health and social needs interact. For people experiencing homelessness, physical illness, mental health, substance use, trauma, housing, income, legal needs and social participation may influence one another. Treating each issue independently can therefore leave the underlying situation unchanged. Service availability alone is insufficient. Access may be obstructed by administrative, logistical, financial, relational, digital or psychological barriers. A technically correct referral may still result in no care. Integrated Health and Social Care responds by reorganising the system around the person. Its four conceptual foundations are:

- **Whole-Person Integrated Care** because needs interact;
- **Low-Barrier and Equitable Access** because formal availability does not guarantee meaningful access;
- **Trust-Based and Trauma-Informed Practice** because relationships, safety and previous experiences affect engagement;
- **Health and Housing as Rights – System Responsibility** because people should not be expected to overcome structural fragmentation alone.

These principles are reinforced by IHSC: person-centred care, Housing First values, structured needs assessment, evidence-informed design, integrated entry points, outreach, multidisciplinary cooperation, clear pathways, triage, continuity across housing transitions, digital health where useful, partnerships, capacity building, monitoring, adaptation, sustainability and system change. Together they create a coherent conceptual model:

- ➔ **Housing provides a foundation.**
- ➔ **Accessible services create an entry point.**
- ➔ **Trust creates engagement.**
- ➔ **Whole-person assessment identifies complexity.**
- ➔ **Multidisciplinary care brings together the necessary expertise.**
- ➔ **Coordination turns separate interventions into a pathway.**
- ➔ **Continuity protects progress during transitions.**
- ➔ **Data makes the model learn.**
- ➔ **Partnerships connect the service to the wider ecosystem.**
- ➔ **Evidence creates the possibility of sustainability, replication and system change.**

This is the conceptual foundation on which the remainder of the PMG is built.

THE FIVE CASES AT THE END OF LEVEL 1

At this stage, the cases have helped illuminate five different questions:

HCSOM — How do we reach and coordinate care for someone who remains outside stable housing?

NMP — What changes when permanent housing comes first, and how should support continue afterwards?

HESED — How do inadequate housing, poverty, community context and unequal access shape health?

Casa Ioana — How should trauma, safety and family circumstances change the way services operate?

VPR — How can integrated support remain continuous throughout the pathway from severe housing exclusion into permanent housing?

These are no longer only conceptual questions. They lead directly to service design.

SOLACE-CEE Project Methodology Guidelines

LEVEL 1 — CONCEPTUAL FOUNDATIONS

Understanding Homelessness, Complex Needs and the Foundations of Integrated Care

Builds the shared conceptual understanding needed before designing or implementing integrated care.

1 Understanding Homelessness and Housing Exclusion



- Homelessness beyond rooflessness
- ETHOS and the continuum of housing exclusion
- Structural, institutional and individual dimensions
- Homelessness as a pathway, not an identity
- Rough sleeping and entrenched homelessness
- Shelters and temporary accommodation
- Family homelessness and hidden homelessness
- Informal settlements and inadequate housing
- Institutional pathways into homelessness
- Intersectionality, stigma and professional attitudes

2 Health and Social Needs of People Experiencing Homelessness



- Social determinants of health and health inequalities
- Multimorbidity and complex needs
- Physical health, mental health and substance use
- Trauma, health literacy and service literacy
- Housing as a health intervention
- Income, legal support and material security
- Employment, participation and community integration
- Family and children's needs
- Barriers to care
- Why fragmented systems fail people with complex needs

3 Foundations of Integrated Health and Social Care

Defines the SOLACE-CEE response to fragmentation.

4 Core Principles

1. Whole-Person Integrated Care
2. Low-Barrier and Equitable Access
3. Trust-Based and Trauma-Informed Practice
4. Health and Housing as Rights – System Responsibility

Operating Principles and Mechanisms

- person-centred care
- Housing First values
- Trauma-Informed Care
- recovery orientation and harm reduction
- outreach and the prevention–outpatient–specialist continuum
- Integration HUBs
- multidisciplinary teams and case management
- triage and continuity of care
- digital health and telemedicine
- lived experience, data-informed practice and continuous learning

Cross-cutting cases used throughout the PMG

HCSOM / MALTAI	NMP	HESED	Casa Ioana	VPR
individual in rough sleeping / shelter homelessness	person in Housing First	family in an informal settlement / inadequate housing	family in shelter accommodation	continuity from homelessness into permanent housing

Level 1 answers: Why integrated care? For whom? And on what conceptual foundations?

3.23. Transition to Level 2 — From Principles to Practice

Level 1 deliberately does **not** prescribe a single organisational model. SOLACE-CEE operates from the principle that common methodological foundations can and should be implemented differently depending on local legislation, healthcare financing, housing availability, social protection, workforce, digital infrastructure, existing services and population needs. The PMG explicitly identifies local adaptation as a core methodological requirement. The next question is therefore not:

What does the SOLACE model look like?

It is:

How can an organisation translate these principles into an integrated model that works in its own context?

Level 2 answers that question step by step. It starts by understanding the local context and population rather than by choosing services in advance. It then moves through needs assessment, readiness, service design, multidisciplinary teams, pathways, service provision, Trauma-Informed Care, digital health, monitoring and adaptation. In other words:

- ➔ **Level 1 establishes what must remain true.**
- ➔ **Level 2 determines how it can be made real.**

The five cases will now move with us into that implementation process. For the **HCSOM case**, Level 2 will ask how needs should be assessed and an accessible pathway designed for someone moving between rough sleeping and shelter accommodation. For the **NMP case**, it will ask how health, mental-health and social support should be organised around Housing First and permanent housing. For the **HESED case**, it will ask how community-based integrated care can respond to families living in informal settlements and inadequate housing. For the **Casa Ioana case**, it will ask how family safety, trauma-informed practice, health, social support and housing pathways can be brought together. For the **VPR case**, it will ask how multidisciplinary care can remain continuous from outreach and temporary accommodation through integrated outpatient services and into Housing First. The methodological question therefore changes from:

Why is integrated care needed?

to:

How do we build it around these people, in these contexts?

This is the starting point for **Level 2 — From Principles to Practice**.

II. LEVEL 2 — FROM PRINCIPLES TO PRACTICE

Designing and Implementing Integrated Health and Social Care

Level 1 established the conceptual foundations of Integrated Health and Social Care for people experiencing homelessness. It explained why homelessness must be understood as a dynamic interaction of housing, health and social conditions; why conventional fragmented systems frequently fail people with complex needs; and why whole-person care, equitable access, trauma-informed practice, Housing First values, continuity and system responsibility form the conceptual foundation of the SOLACE-CEE approach.

Level 2 translates these principles into implementation. Its purpose is not to provide a blueprint for one standardised service model. The experience of SOLACE-CEE demonstrates why such an approach would be inappropriate. Homelessness takes different forms in different locations. Some organisations primarily work with people sleeping rough or living in shelters. Others support families experiencing homelessness, people living in informal or inadequate housing, or individuals already housed through Housing First. Health systems differ, as do social-service structures, housing markets, local-government responsibilities, professional competencies, financing mechanisms and the availability of specialist care. An integrated model developed for one environment therefore cannot simply be transferred unchanged into another. The methodology instead provides a structured implementation process. Organisations begin by understanding the population and the wider service environment. They identify needs and gaps, assess whether the organisation and local ecosystem are ready for integration, and only then determine what kind of service model is required. The model is subsequently translated into multidisciplinary team arrangements, care pathways and concrete modes of service delivery. Trauma-Informed Care and digital health are integrated where relevant, while monitoring, evaluation and continuous learning allow the model to evolve over time. This implementation logic reflects both the SOLACE Methodological Cycle. It intentionally places structured needs assessment and data before service design, and it treats the Integration HUB, multidisciplinary working, outreach, pathways, continuity, digital health and partnerships as components of one interconnected model rather than stand-alone interventions. The central logic of Level 2 can therefore be expressed as:

Understand the context → Assess needs → Assess readiness → Design the model → Build the team → Build the pathways → Deliver care → Embed TIC and digital health → Monitor → Learn → Adapt.

The process is sequential enough to guide implementation, but it is not rigidly linear. Organisations may need to return to earlier steps as new information emerges. A service may discover that the population differs from the initial assessment, that a referral pathway does not work, that a partner lacks sufficient capacity or that a different form of outreach is required. Integrated care should therefore be understood as an adaptive

implementation process rather than a programme that is designed once and then simply operated.

CROSS-CUTTING CASES — From conceptual questions to implementation decisions

The five cross-cutting cases introduced in Level 1 now become implementation lenses. They are not organisational profiles and they are not models to be copied. Each case is used to test how the same SOLACE-CEE principles lead to different operational choices when the population, housing situation, service ecosystem and local constraints differ.

The **HCSOM case** follows an adult moving between rough sleeping and shelter accommodation; **NMP** follows a person moving from long-term homelessness into permanent Housing First; **HESED** focuses on a family living in an informal settlement or severely inadequate housing; **Casa Ioana** follows a mother and children in temporary shelter accommodation; and **VPR** follows a family across severe housing exclusion, temporary accommodation and Housing First. Throughout Level 2, the cases help answer a practical question: what would this implementation step mean for this person, in this context?

4. Understanding the Local Context

The first practical task is to understand the environment in which integrated care will operate. A common mistake in service development is to begin with the organisation itself: the professionals it can employ, the funding available, the premises it owns or the interventions it already knows how to deliver. These questions are important, but if they are asked too early they can cause service design to reproduce the organisation's existing structure rather than respond to the needs of the population. The SOLACE-CEE methodology therefore starts elsewhere. Before asking:

What can we provide?

organisations should ask:

What is happening in our community now?

This requires looking at homelessness as a local ecosystem rather than as the responsibility of one service. An organisation should first **understand who experiences homelessness and severe housing exclusion in the area.** Rough sleeping is one part of this picture, but local analysis should also consider people living in emergency and temporary accommodation, families in shelters, people staying informally with relatives or friends, people living in informal settlements or inadequate housing, people leaving institutions without somewhere appropriate to live, and people whose homelessness has formally ended through Housing First or another housing programme but who continue to require substantial health and social support. The objective is not necessarily to produce a perfect epidemiological count before implementation can begin. In many settings, homelessness data will be incomplete. What is required is a sufficiently robust understanding of the local population to avoid designing services around assumptions. Different information sources should therefore be combined wherever possible. Homelessness counts, administrative records, municipal data, service-use information, healthcare records, local studies, community knowledge and the experience of frontline organisations can each contribute a different part of the picture. None should automatically be treated as complete. Existing service statistics, for example, describe people who are already visible to the system but may reveal relatively little about hidden homelessness or groups that avoid formal services.

Once the population is broadly understood, the organisation should **map the existing service environment**. This mapping should extend well beyond the homelessness sector. Integrated care depends on the relationship between homelessness services and primary healthcare, hospitals, psychiatry, psychology, addiction services, pharmacies, outreach, social services, housing programmes, municipal authorities, employment services, legal support, domestic-violence services, family and child services and community organisations. The purpose of the exercise is not to produce another directory of available services. A directory tells us where services exist. An implementation map should help us understand **whether and how people can actually move between them.** For example, a city may have psychiatric care, but people experiencing homelessness may face long

waiting times, formal referral requirements or difficulty attending scheduled appointments. The actual gap may therefore not be the absence of psychiatry. It may be the absence of an accessible psychiatric pathway. Similarly, a hospital may deliver clinically appropriate acute treatment while having no effective mechanism for discharging a patient who lacks suitable accommodation. A housing service may exist but exclude people with high support needs. Primary care may formally be universal while registration rules make it difficult for people without a stable address to access it. These spaces between services are often where fragmentation becomes visible. Organisations should therefore **examine not only what exists but where transitions fail**. Where do referrals end without follow-up? Which groups are repeatedly rejected? Which services assume that another institution is responsible? Where do administrative rules make access impossible? Which geographical or transport barriers prevent attendance? Where does a person's housing status change and established support disappear? Understanding these gaps begins to reveal the local architecture of fragmentation.

The policy and institutional environment should also be considered early. Integrated services do not operate outside legislation, financing and professional regulation. Even at this initial stage, organisations should understand the basic rules governing healthcare provision, professional competencies, social-service registration, data protection, information sharing, public reimbursement and housing responsibilities. A detailed legal analysis may come later, but a service model should not be designed around assumptions that turn out to be institutionally impossible. Context analysis should nevertheless **avoid becoming exclusively deficit-oriented. Local systems also contain assets that can be built upon**. A trusted outreach organisation, a supportive general practitioner, an existing Housing First programme, municipal premises, a university partner, a committed hospital department or a strong community organisation may provide foundations on which integration can grow. This is particularly important because the SOLACECEE methodology **does not assume that integrated care must be created by replacing existing services**. In many situations, the most effective intervention will be **to connect and strengthen what already exists.**

By the end of the local-context analysis, an organisation should be able **to identify the initial integration opportunity**. It might discover that people living in shelters have strong social support but almost no primary healthcare access. It might identify good healthcare but weak connections with housing. A Housing First service may find that participants lose continuity in specialist mental healthcare. A community organisation working in an informal settlement may identify a major gap in access to mainstream healthcare. In another city, services may already exist across sectors but operate almost entirely in parallel. These situations require different responses.

CASE COMPARISON — The same context analysis produces different integration priorities

For the **HCSOM case**, context analysis may show that homelessness services, outreach and healthcare already exist, while the principal implementation needs lie in making the connections between them more accessible and continuous. For the **HESED family**, the

analysis may reveal a different architecture: health and social services may formally exist, but distance, poverty, discrimination, informal housing conditions or weak links with mainstream institutions may make them difficult to use.

For the **NMP case**, the relevant gap may emerge after housing is secured, when health, mental-health or social support needs to remain connected to a permanent tenancy. For **Casa Ioana**, the map must include not only homelessness and healthcare services but also domestic-violence, family, child and housing pathways. For **VPR**, the critical question is whether outreach, outpatient care, temporary accommodation and housing-based support form a continuous pathway. The cases therefore reinforce the purpose of context analysis: identify the local point of fragmentation before deciding what to build. The methodology therefore begins not by asking which SOLACE-CEE partner model should be replicated, but by **identifying where local fragmentation occurs and what form of integration is most needed.** The experience of the Hungarian Charity Service of the Order of Malta illustrates one version of this logic. HCSOM operates within an extensive homelessness infrastructure that already includes health centres, shelters, night shelters, day centres and outreach. Within SOLACE-CEE, integrated care could therefore build on an existing service environment and strengthen connections between health, mental health, social support, telemedicine and remote monitoring. The transferable lesson is not the organisational structure itself. It is the principle that integration should begin by identifying and connecting the resources already present within the local ecosystem.

5. Identifying the Target Population and Assessing Needs

Understanding the wider context is followed by a more focused question: **Who exactly is the integrated service intended to support, and what combination of needs should it be capable of addressing?** Needs assessment is a central component of the SOLACE-CEE methodology because it connects evidence with implementation. It prevents an organisation from selecting interventions first and searching for a target population later. Instead, **information about the population becomes the basis for decisions** about service content, staffing, location, outreach, digital tools, partnerships and pathways. The target population should be clearly defined, but definitions must be handled carefully. They should help the organisation understand whom it is designing for without becoming unnecessary gatekeeping mechanisms. A description such as people experiencing homelessness may be appropriate at policy level but too broad for operational design. The needs of a family living in an informal settlement may differ substantially from those of an individual with severe mental illness sleeping rough or a person already housed through Housing First. A more **operational definition** may therefore **combine housing situation with relevant needs**. One service might focus on adults experiencing prolonged or recurrent homelessness with significant physical-health, mental-health or substance-use needs and substantial barriers to mainstream healthcare. Another might focus on families with children living in homelessness, informal settlements or severely inadequate housing who require coordinated health, housing and social support. The target-group definition should **guide design, not determine deservingness.** Needs should then be **assessed at both population and individual level.**

Population-level assessment asks what needs recur often enough to justify a particular service capacity. If a high proportion of the target population experiences untreated chronic illness, accessible primary care and nursing may be required. If mental-health needs are widespread but specialist services are practically inaccessible, psychiatric or psychological capacity may need to be embedded or formally connected. If families form a substantial part of the population, paediatric, developmental and family-sensitive pathways become relevant.

Individual assessment has a different function. It determines what a particular person or family needs and wants at a given point in time. Population-level evidence may justify the presence of an employment specialist within the programme, but that does not mean employment is an appropriate immediate goal for every individual.

The needs-assessment framework should therefore remain holistic. The PMG explicitly calls for assessment across health, mental health, substance use, housing, income, employment, legal needs, family circumstances, trauma, access to services and other relevant domains. The objective is not to create the longest possible assessment form. It is to understand how different needs interact. A person may have poorly controlled diabetes, depression, alcohol dependence, housing instability and unpaid debt. **Treating each item as a separate problem generates a list of referrals. Understanding the interaction**

between them produces a care strategy. Perhaps unstable housing makes food and medication management difficult. Depression affects the person's ability to attend appointments. Debt threatens housing stability. Substance use is partly a coping strategy. The support plan must therefore consider the interdependence of these factors. This **whole-person perspective is one of the most important differences between integrated care and parallel service provision. People experiencing homelessness should also participate directly in needs assessment.** Professional and administrative data can tell organisations a great deal about service use, diagnoses and formal needs, but they cannot fully explain how services are experienced. Rather than only asking people which services they would like, organisations should explore actual pathways. *What happens when you become ill? Where do you go? What makes attending healthcare difficult? Which services do you avoid? What happened the last time you were discharged from hospital? What support have you found useful? What is the most important problem for you at present?* Such questions frequently reveal barriers that are invisible in administrative data.

Professionals and stakeholders should also be consulted. Different parts of the system see different problems. Outreach teams may understand trust and engagement. Hospitals may identify repeated emergency use and difficult discharge. Social workers may understand documentation and entitlement barriers. Housing teams may recognise tenancy risks. Municipalities may understand public infrastructure and housing availability. Divergence between these perspectives is itself informative. A healthcare professional may believe the main problem is missed appointments, while service users describe transport, fear of stigma or confusing registration procedures. Needs assessment should surface these differences rather than force premature consensus. **A particularly important distinction is between unmet needs and poorly met needs.** A service may formally exist while failing to meet the needs of the population. A city may therefore not need another psychiatric provider; it may need a different route into psychiatric care. The distinction has significant implications for both cost and system design.

Once findings are available, they must be **translated into implementation consequences**. Every major needs-assessment result should lead to the question: **What does this finding mean for the design of the integrated model?** If people repeatedly lose follow-up after hospital discharge, the model needs a discharge and transition pathway. If many people do not access clinics at all, outreach or low-threshold access must become stronger. If trauma is pervasive, Trauma-Informed Care cannot remain optional training for selected staff. If families with children are a priority population, service hours, spaces and professional composition may need adaptation. If specialist care is geographically unavailable, digital-health solutions may be worth exploring. The needs assessment therefore becomes the bridge between evidence and architecture.

CASE LENS — Needs assessment should change the model, not merely describe the population

Applied to the **HCSOM case**, a needs assessment might identify multimorbidity, mental-health or substance-use needs, repeated emergency care, difficulties attending appointments and weak continuity between street outreach, shelters and healthcare. These findings would point towards proactive outreach, accessible primary care, stronger navigation and specialist pathways rather than a conventional appointment-only model. For the **HESED family**, the assessment may need to capture children's health, women's health, nutrition, housing conditions, income, documentation, social protection, discrimination and access to mainstream care. For **Casa Ioana**, safety, trauma, family functioning and the needs of both parents and children may be central. For **NMP** and **VPR**, assessment must continue after housing because the priorities that become visible in a stable home may differ from those that dominated during homelessness. In each case, the assessment is useful only if its findings are translated into concrete design consequences. The **HESED model** demonstrates why this matters. Working with families and individuals in housing instability and vulnerable Roma communities requires a model sensitive to family relationships, children's health, nutrition, women's needs, social protection, community dynamics and healthcare access. A design based solely around clinical appointments would fail to address the context in which those health needs occur. The response therefore combines health support, social services, outreach and community engagement.

6. Assessing Readiness for Integrated Care

A population may clearly need integrated care, but this does not automatically mean that an organisation or local system is ready to implement it. **Readiness assessment allows organisations to identify the distance between their current capabilities and the model they want to build.** This is where the SCIROCCO Maturity Model (and SCIROCCO tool) becomes particularly useful within the PMG. SCIROCCO was developed to help organisations and regions reflect on the conditions required for integrated care. In the SOLACE-CEE methodology, it should not function as an examination that an organisation either passes or fails. Its value is diagnostic and developmental. An organisation may have strong relationships with people experiencing homelessness but limited healthcare expertise. Another may operate sophisticated clinical services but have little understanding of low-threshold homelessness work. A third may have excellent services but no reliable data infrastructure. A fourth may have good internal capacity but weak partnerships with public systems. All of these organisations can potentially develop integrated care, but their implementation pathways will differ. Readiness should therefore be examined across several domains. Leadership and governance are fundamental. Senior management must understand why integration is being pursued and be prepared to support the organisational changes it requires. Integrated care can affect staffing, responsibilities, data, partnerships, budgets and professional culture. Without leadership commitment, integration can remain dependent on individual enthusiastic staff and disappear when those individuals leave. Workforce capacity also matters.

Organisations should examine not only whether they have enough staff, but whether they possess the required mix of competencies and whether professionals are prepared to work across disciplinary boundaries. Partnership readiness is equally important. Integration cannot be created through organisational capacity alone. Relevant hospitals, healthcare providers, social services, housing organisations and public authorities must have at least some willingness and ability to cooperate. Digital readiness may determine whether telemedicine, shared information systems or remote monitoring are realistic. Data and evaluation capacity will influence whether implementation can be monitored and improved. Financing readiness affects whether the service can move beyond an initial pilot. The regulatory environment may also create important constraints. Professional competencies, healthcare licences, reimbursement rules and data-protection requirements can shape what an organisation can provide directly and what must be organised through partnership. **The purpose of readiness assessment is not to delay implementation until all conditions are ideal.** In most real environments they never will be. Rather, it allows the organisation t**o distinguish between what can be implemented now, what requires preparation and what may need to be developed progressively.** A phased approach is often preferable. An organisation may begin by linking outreach, social work and primary care. Later it may add mental-health capacity, improve specialist pathways, introduce telemedicine or develop more intensive housing support. Another service may begin with a small coordinated team and gradually formalise partnerships

and data systems. The important point is that each phase should **contribute to the longer-term architecture of integrated care.** Readiness assessment should therefore end not with a score but with **an implementation improvement plan.** The organisation should know its strengths, major gaps, implementation risks and priority actions.

CASE COMPARISON — Readiness is context-specific

The five cases also demonstrate why readiness cannot be reduced to one organisational score. A service working with the **HCSOM case** may already have strong outreach and homelessness infrastructure but need to strengthen specialist coordination, digital pathways or continuity. An organisation working with the **HESED case** may have deep community trust and outreach capacity while needing stronger formal links with mainstream healthcare and public systems. A Housing First organisation such as the context represented by **NMP** may have strong housing and person-centred practice but need to examine whether healthcare and mental-health pathways are sufficiently embedded. **Casa Ioana** may need to assess whether family, safety, health and housing services can coordinate without repeatedly transferring responsibility. VPR may need to examine whether the organisational and partnership infrastructure can sustain continuity across outreach, outpatient healthcare and permanent housing. SCIROCCO is useful precisely because it turns these differences into a structured discussion about strengths, gaps and next steps. This approach is consistent with the wider SOLACE methodological logic: integrated care is a process of increasing maturity rather than a binary state.

7. Designing the Integrated Service Model

Only after the local context, target population, needs and readiness have been examined should the organisation **design the actual service model.** The first design task is to define **the model's purpose**. A programme may seek to improve healthcare access for people experiencing chronic homelessness, to ensure continuity for families moving from homelessness into housing, to connect residents of an informal settlement with health and social systems, or to integrate healthcare into an existing Housing First programme. A clear purpose prevents the service from becoming an accumulation of unrelated activities. The organisation should then identify the functions needed to achieve that purpose. These functions may include engagement, assessment, primary healthcare, mental-health care, social support, housing assistance, case management, navigation, referral, prevention, digital health and follow-up. At this point, an important **distinction should be made between functions and services**. The model may need a mental-health function, but this does not necessarily mean employing a psychiatrist directly. It may instead require a strong specialist partnership, telepsychiatry or regular consultation. The model may require legal support, but an external legal organisation may be able to provide it effectively. It may require housing support without owning housing itself. Integrated design therefore asks three related questions:

What must the model be able to do?

Which functions should we provide directly?

Which functions can be reliably accessed through partners?

This is where the concept of the Integration HUB becomes useful. Within SOLACE-CEE, a HUB should not be understood simply as a building containing several services. **A HUB is an accessible entry point into a wider system of integrated support.** In some places, this may be a dedicated centre where healthcare and social services are co-located. In another context, it may operate through an existing shelter or community centre. A Housing First team could fulfil some HUB functions through mobile work and strong external pathways. Outreach and digital health may create a distributed rather than building-based model. The organisational form can differ. The functional requirement remains the same: **once a person enters through one part of the system, they should be able to reach the other support they need without having to reconstruct the network themselves.** Co-location can be valuable, especially where it removes access barriers and strengthens professional communication. Primary healthcare, nursing, psychiatry, psychology and social counselling may operate effectively in the same location. **But co-location should not become an objective in itself.** A specialist service that already functions well and is accessible may be better retained externally. **The design challenge then shifts from co-location to pathway quality.** For every external service the model depends upon, the organisation should know how access will work, who makes contact, whether accompaniment is required, how information returns to the team and what happens if the person does not attend. **Low-threshold access should be designed deliberately.** A

service that intends to reach people experiencing homelessness should examine whether conventional appointment systems, documentation requirements, opening hours or locations create unnecessary barriers. Some populations may benefit from walk-in access. Others may engage through outreach or partner referral. Families may need appointment arrangements that recognise caring responsibilities. People without phones may require alternative communication. A digital option may increase access for some while excluding others. The service package itself should emerge from the needs assessment. Depending on context, it might include primary care, nursing, psychiatry, psychology, social work, housing support, legal assistance, employment support, addiction services, outreach, health promotion, medical respite or telemedicine. The central implementation principle is:

Do not build the largest possible service package. Build the combination of functions required to create a coherent pathway for the target population.

CASE PATHWAYS — One Backbone, different service architectures

For the **HCSOM case**, the coherent pathway may be distributed across outreach, shelters, existing health centres, specialist care, telemedicine and remote monitoring. For **NMP**, the organising platform is permanent housing, with flexible multidisciplinary support connected to health and mental-health services. For the **HESED family**, the model may need to start in the community and connect health, social and family support with mainstream institutions. For **Casa Ioana**, temporary accommodation can serve as an accessible entry point, but the model must connect safety, family support, healthcare, case management and a pathway towards permanent housing. For **VPR**, integration may connect outreach, outpatient health and social services, and long-term support in Housing First. The architectures differ, but the functional test is identical: can the person move through the required support without being expected to integrate the system alone? The **Slovak VPR model** illustrates one possible response. Its integrated architecture connects outreach services, outpatient healthcare and counselling, and long-term housing-based support for families. The important learning is not that this exact combination should be replicated elsewhere. It is that **continuity has been built across different settings**: people can be reached while experiencing homelessness, access health and social support through HUB services, and continue receiving support after moving into Housing First. This is a practical expression of one of the strongest Backbone principles: the service relationship should follow the person rather than terminate when housing status changes.

8. Building the Multidisciplinary Team

Once the service model has been designed, the next task is to determine what professional expertise is required and how those professionals will work together. Integrated care requires multiple perspectives because the problems it addresses cross disciplinary boundaries. Depending on the target population, a multidisciplinary team may include general practitioners, nurses, psychiatrists, psychologists, social workers, outreach workers, addiction specialists, housing workers, employment specialists, lawyers, peer workers and digital-health or telemedicine support roles. However, **the simple presence of different professions does not create a multidisciplinary team**. If each professional independently assesses the person, maintains separate priorities and communicates only occasionally, the service remains parallel rather than integrated. The first design decision should therefore be **to distinguish between the core multidisciplinary team and the extended care network.** Core team members are those who regularly contribute to coordinated care and need structured mechanisms for communication and case review. The extended network consists of specialist services and partners involved when particular needs arise. This distinction allows the organisation to create meaningful integration without attempting to employ every possible professional. Roles and responsibilities must then be explicit. Teams should know who conducts initial assessment, who carries clinical responsibility, who coordinates social support, who manages housing-related interventions, who follows referrals, who contacts external providers and who ensures follow-up when contact is lost. **Unclear responsibility is one of the most common causes of fragmentation.** In integrated care, the sentence I referred the person, so my part is complete is often insufficient. Referral creates another question:

Who knows what happened next?

Tools such as **RACI matrices** can help clarify responsibility, accountability, consultation and information-sharing roles, particularly when several organisations cooperate. **Regular multidisciplinary meetings or case conferences** provide another important integration mechanism. Their purpose is to develop a shared understanding of complex situations and agree coordinated actions. **Not every person requires intensive multidisciplinary discussion**. The frequency and depth of review should correspond to complexity and risk. Some people may primarily use one service and need only occasional coordination. Others may require frequent discussion among several professionals. Team communication also requires **a shared conceptual language.** Medical professionals may focus on clinical diagnosis and treatment. Social workers may prioritise functioning, relationships and structural barriers. Housing professionals may focus on tenancy stability. All perspectives are relevant, but integration requires enough mutual understanding that these perspectives contribute to a common plan rather than compete. Training therefore has a structural role within IHSC. Staff wellbeing and safety must also be built into the model. Work involving homelessness, trauma, severe illness and repeated crisis can generate emotional strain, moral distress and risk of burnout. Supervision, reflective practice, debriefing, safety procedures and realistic workloads should therefore

form part of the operating model. A trauma-informed organisation should recognise that the wellbeing of staff affects the quality and continuity of support provided to service users.

CASE LENS — The target population determines the multidisciplinary configuration

The **HCSOM case** may require close cooperation among outreach workers, primary-care professionals, mental-health or addiction specialists and social workers. The **NMP case** may place housing support and psychologically informed or mental-health expertise at the centre of the core team while drawing on healthcare through an extended network. The **HESED case** may require community workers, health professionals and social support able to work with the whole family and the realities of an informal settlement. For **Casa Ioana**, social work, trauma-informed psychological support, family and child expertise, healthcare and housing coordination may need to operate as one shared pathway. For **VPR**, health professionals, social workers, outreach and housing-support staff may all contribute at different stages. These examples illustrate why the MDT should be built from recurring needs and pathways rather than from a generic list of professions.

9. Designing Care Pathways and Ensuring Continuity

Care pathways are the point at which separate services become an integrated system. An organisation can have excellent professionals, accessible premises and strong individual interventions while still providing fragmented care if people repeatedly become lost between services. Pathway design should therefore **begin from the service user's perspective.** Rather than drawing an organisational chart, **map the actual journey.** A person sleeping rough might first encounter an outreach worker. The worker builds trust, identifies a health need and connects the person to primary healthcare. A nurse or GP identifies the need for specialist treatment. The appointment is arranged and accompanied. The person is later admitted to hospital. Before discharge, the integrated team coordinates follow-up and housing support. When housing becomes available, health and social support continues through the transition. **The pathway is not the list of services involved. It is the connection between them.** Integrated pathways should allow **multiple entry points**. A person may enter through outreach, a clinic, shelter, hospital, Housing First service or social worker. A **no-wrong-door orientation** means that the initial service assumes responsibility for helping connect the person with the appropriate part of the integrated system rather than redirecting them without support. **Initial assessment should distinguish between immediate risk and comprehensive needs.**

Triage may need to identify urgent medical conditions, acute psychiatric risk, safeguarding concerns, severe withdrawal, violence or other emergencies. More **comprehensive assessment** can then follow once immediate safety has been addressed. **For people with complex needs, assessment should lead to an integrated care or support plan.** This plan should reflect the person's priorities as well as professional assessment and should clearly identify goals, actions, responsibilities and review points. **Referral pathways require particular attention.** Passive signposting—giving a person a telephone number or address—may be appropriate for somebody with stable circumstances and high capacity to navigate systems. For people facing multiple barriers, **a warm handover is often more appropriate.** A warm referral may involve contacting the receiving provider, arranging the appointment, sharing relevant information with consent, explaining the process, accompanying the person and confirming whether care actually occurred. The level of support should be proportionate to need.

CROSS-CUTTING CASE — What a warm pathway looks like in practice

For the person represented by the HCSOM case, a warm pathway may begin with an outreach worker who establishes contact, helps arrange a primary-care assessment, coordinates a specialist appointment and remains involved after hospital treatment. The critical implementation feature is not the number of referrals but the continuity between them. For the Casa Ioana family, a warm pathway may require coordinated transfer between shelter-based support, healthcare, psychological or specialist services and housing planning without forcing the mother to repeatedly reconstruct the family's history. For the VPR family, the same principle extends across housing status: the professionals involved before the move should coordinate with those supporting the

family after the move so that permanent housing becomes a transition within the pathway rather than an administrative endpoint. Transitions deserve special attention because they are points where continuity frequently breaks down. Hospital discharge is a particularly important example. A person may be medically ready to leave hospital while still lacking a safe place to recover. Without coordination, the healthcare system can effectively discharge someone back into the conditions that contributed to illness. Medical respite or intermediate-care models can bridge this gap where appropriate, providing a temporary environment for recovery while health, social and housing planning continues. Movement into permanent housing is another critical transition. Housing represents an essential achievement but should not automatically trigger withdrawal of support. Newly housed people may still need help with healthcare, routines, social isolation, finances, mental health, substance use or community participation. Families may require ongoing support while children and parents adjust to a new environment. The intensity of support can reduce as stability increases. Continuity does not mean permanent intervention. It means that support decisions are driven by need and recovery, not merely by a change in administrative category. Housing First Poland provides a useful illustration. Permanent housing is not treated as the end point after which support disappears. Housing creates a foundation from which recovery, mental health, social participation and autonomy can develop. Flexible support follows the person into housing rather than remaining attached to a homelessness facility. This principle – continuity across housing transitions—is one of the defining features of the PMG.

CASE COMPARISON — Housing changes the pathway but should not break it

The NMP and VPR cases make this particularly visible. In the NMP case, Housing First provides permanent housing first and support follows the person into the tenancy. In the VPR case, the longitudinal pathway can connect severe housing exclusion and outreach with outpatient integrated care and then continue into Housing First. In both cases, the service mix and intensity may change after housing, but the relationship does not end simply because the administrative category of homelessness has changed.

10. Organising Integrated Service Delivery

Once the model, team and pathways are defined, implementation becomes an operational task. The central question changes from *What should the model include? to:* ***How will people actually receive support in everyday practice?***

Different modes of delivery should be understood as parts of one continuum rather than separate programmes. Outreach is often the first point of engagement. Its purpose may include relationship building, basic assessment, health intervention, harm reduction, follow-up, health education and connection with other services. The primary aim is not simply to make contact. **Outreach should create a bridge into wider support while respecting that trust may develop gradually. Accessible primary healthcare** may be particularly important where mainstream services do not effectively reach people experiencing homelessness. Primary care can provide preventive healthcare, chronic-disease management, treatment of acute conditions, medication support, vaccination and referral to specialists. **The longer-term objective should nevertheless be inclusion rather than permanent segregation.** Where mainstream services can become accessible and responsive, integrated programmes should strengthen those connections rather than create unnecessarily separate health systems for people experiencing homelessness. **Mental-health and psychological support** may be delivered directly within a HUB, through external specialists, outreach or telemedicine. The appropriate arrangement depends on population needs and local capacity. What matters is that the mental-health pathway is accessible and connected with housing, physical healthcare and social support. **Social work** addresses many of the determinants that affect health and housing stability, including benefits, income, documentation, family circumstances, debt, access to services and administrative barriers. In an integrated model, these issues are not secondary to healthcare. They are part of the environment in which clinical outcomes are produced. **Housing support** should likewise be understood as integral rather than external. This may involve Housing First, social rental models, housing search, tenancy sustainment, landlord mediation or support during and after transition into housing. Where housing is provided by another organisation, the partnership must be strong enough to maintain continuity. **Medical respite care** may be required for populations where people repeatedly leave hospital but cannot safely recover in shelters or on the street. Medical respite provides short-term recuperative care combined with social support and transition planning. Its role should remain clearly defined: it is a bridge between healthcare and a safer longer-term setting, not a substitute for housing. **Prevention and health promotion** should also remain part of the service package. Integrated care should not become exclusively crisis-driven. Vaccination, screening, health education, nutritional support, sexual and reproductive healthcare, harm reduction and chronic-disease monitoring can prevent deterioration and reduce reliance on emergency services. The appropriate balance among outreach, outpatient care, shelter-based services, community services, housing-based support and specialist referrals will vary by

context. **What makes these modes part of one integrated model is not where they occur, but whether they are connected through a coherent pathway.**

CASE COMPARISON — Different modes of delivery for different realities

The **HCSOM case** may rely heavily on street and shelter outreach linked to fixed healthcare and specialist services. The **HESED case** may require community-based delivery close to families living in informal or inadequate housing, with active support into mainstream healthcare. **Casa Ioana** may use shelter-based support as one point of contact while coordinating external health, family and housing services. **NMP** demonstrates delivery in and around permanent housing, where support can be mobile and flexible rather than tied to a homelessness facility. **VPR** illustrates a continuum in which outreach, outpatient services and housing-based support each have a role at different stages. **The practical lesson is that service settings should follow access needs and the person's pathway rather than organisational convenience.**

11. Embedding Trauma-Informed Care in Everyday Practice

Trauma-Informed Care (TIC) was introduced in Level 1 as one of the four core foundations of IHSC. At implementation level, this principle must become visible in everyday interactions, physical environments, organisational procedures and team culture. **A service cannot become trauma-informed merely by providing staff training.** Training may begin the process, but the organisation must examine how people actually experience the service. **The physical environment is one place to start.** Privacy, noise, crowding, lighting, waiting arrangements, signs, security procedures and room layout can influence whether people experience a service as safe and respectful. Some aspects may appear minor from an organisational perspective but have significant impact on people with histories of violence, institutionalisation or prolonged insecurity. **Procedures should also be predictable.** People should understand what information is being collected, why it is needed, who will have access to it and what will happen next. Unexpected decisions and unexplained rules can reproduce experiences of powerlessness. **Communication should therefore be clear, respectful and transparent.** Trauma-informed practice also requires professionals to **consider the meaning behind behaviour.** Anger, withdrawal, missed appointments, reluctance to disclose information or difficulty making decisions may reflect many factors, including trauma, fear, cognitive overload or previous negative experiences. This does not mean that unsafe behaviour must be accepted or that professional boundaries disappear. **Boundaries should be clear, consistent and compassionate. Choice and agency should be preserved wherever possible.** People can be offered choices about appointment timing, location, communication method, treatment options or priorities. Not every situation allows extensive choice, but organisations should avoid removing autonomy where there is no compelling reason to do so. Another important implementation issue **is repeated disclosure.** Fragmented services often require people to retell traumatic histories to multiple professionals. Integrated assessment and appropriate information sharing, with consent and within legal requirements, can reduce unnecessary repetition. **TIC should also shape team culture.** Workers regularly exposed to distress, violence, severe illness and systemic barriers can experience emotional strain. Supervision, reflective practice, debriefing and psychologically safe team environments are therefore part of trauma-informed implementation. **The ultimate goal is to move from trauma-aware professionals to a trauma-informed organisation.**

CASE LENS — Casa Ioana: embedding TIC across the family pathway

The **Casa Ioana case** provides a useful implementation test. A mother and children entering temporary accommodation may interact with reception staff, social workers, healthcare providers, psychologists, child or family services and housing actors. Trauma-informed implementation asks whether these contacts form a predictable and respectful pathway: whether privacy is protected, information is explained, repeated disclosure is minimised, choices are offered where possible and safety concerns are addressed without unnecessarily removing agency. The same lens applies beyond family

shelters. In the **HCSOM case**, consistent outreach and non-judgemental engagement may be central to rebuilding trust after repeated exclusion. In Housing First contexts such as **NMP** and **VPR**, trauma-informed practice also matters after housing, when autonomy, relationships and recovery continue to develop. TIC is therefore not attached to one profession or setting; it is embedded in how the entire integrated model operates. In practical terms, this means that safety, predictability, trust, collaboration, choice and empowerment are visible not only in individual conversations but in policies, procedures, leadership and service design.

12. Integrating Telemedicine and Digital Health

Telemedicine and remote monitoring form one of the innovation components of SOLACE-CEE. Their role within the methodology is nevertheless deliberately pragmatic. Technology should be introduced because it solves a meaningful access or continuity problem. The first question should therefore never be:

Which digital platform should we use?

It should be:

What barrier to care are we trying to overcome?

Telemedicine may be useful where specialist capacity is geographically limited, where people face substantial difficulties attending appointments, where psychiatric or other specialist consultation is scarce, or where ongoing chronic-disease monitoring would benefit from remote support. Potential applications include teleconsultation, telepsychiatry, remote monitoring, professional-to-professional consultation and follow-up between face-to-face visits. However, **digital access cannot be assumed.** People experiencing homelessness may lack smartphones, data, reliable electricity, connectivity, digital skills or a private place from which to participate in consultation. Cognitive, literacy or health-literacy barriers may also influence whether digital care is meaningful. **For some populations, therefore, the most effective model is not individual remote access but supported telemedicine.** A trained worker or telemedicine assistant may provide equipment, connectivity, a private environment, technical support and assistance with basic measurements while the clinician participates remotely. The PMG emphasises that preparation, communication, defined professional roles, informed consent, privacy, documentation, safety and follow-up are essential parts of remote care. Telemedicine is therefore not merely a connection between a screen and a clinician. It is an organised clinical process. **Digital care must also be connected with the wider pathway.** If a remote psychiatrist makes recommendations but nobody locally ensures medication, follow-up or coordination, the consultation remains fragmented. The implementation questions must therefore include: *Who identifies the need for teleconsultation? Who prepares the patient? Who supports the session? Who is clinically responsible? Where are recommendations documented? Who implements the follow-up plan? What happens if the person's condition deteriorates? How does an urgent situation escalate?*

The Hungarian SOLACE-CEE implementation offers an important practice example. HCSOM combines telemedicine and telepsychiatry with existing health centres, homelessness services, outreach and remote monitoring. Technology therefore supplements an established human and organisational infrastructure. The transferable lesson is that digital health adds most value when it strengthens an existing care relationship and pathway.

CASE QUESTION — Would digital care solve the barrier in this case?

The answer will differ across the five cases. For **HCSOM**, supported telepsychiatry, teleconsultation or remote monitoring may add value because an existing network of health centres, homelessness services and staff can provide the human infrastructure around the technology. For the **HESED family**, digital tools may help overcome geographic or specialist-access barriers only if connectivity, privacy, equipment and local support are available. For **Casa Ioana**, a shelter may provide a stable and private setting for selected remote consultations. For **NMP** or **VPR**, digital follow-up may support continuity after housing, but it should not replace in-person care when relationship building, physical examination or more intensive support is required. The implementation decision should therefore remain problem-led: introduce technology only when it improves a defined part of the care pathway. It should not replace face-to-face care where physical examination, relationship building or in-person support is required.

13. Monitoring, Evaluation, Learning and Adaptation

Integrated care should be designed as a learning system. Launching the service is not the end of implementation. It is the point at which organisations **begin to learn whether their assumptions were correct.** Monitoring should therefore examine both outcomes and the implementation process itself. An organisation may eventually want to understand whether health outcomes improved, whether housing became more stable or whether emergency-service use changed. But early in implementation it also needs more basic information. *Is the target population actually using the service? Which entry points work? Which services have unexpectedly low uptake? Are referrals completed? Where do people disappear from the pathway? How often are multidisciplinary case discussions needed? Which partners respond reliably? Are some groups underrepresented? Does telemedicine solve the problem for which it was introduced? Are people maintaining contact after moving into housing?* These questions help determine whether the model works as designed. **Quantitative data can identify patterns**. Service contacts, health consultations, referral completion, housing outcomes, hospital use and retention can all provide useful information. **Qualitative evidence explains those patterns.** A low number of psychiatric consultations may reflect insufficient need, but it may also reflect stigma, poor referral procedures, unsuitable scheduling or lack of trust. Interviews with service users and staff can distinguish among these explanations. **People with lived experience should therefore participate in evaluation as well as needs assessment.** Their feedback can identify barriers that routine indicators cannot show. **Staff reflection is equally valuable.** Multidisciplinary teams frequently detect recurring problems before those problems become visible in formal datasets. **Monitoring should consequently lead to structured learning.** Teams should periodically ask: *What is working? What is not working? What surprised us? Which people are not reaching us? Where does the pathway break? What are we doing that no longer adds value? What needs to change?* Adaptation is a normal component of the methodology. An organisation may change opening hours, redesign a referral process, strengthen outreach, modify team roles, add a partner, remove an unnecessary requirement or replace a digital tool. These changes should not automatically be interpreted as deviation from the original model. The key distinction is between adaptable implementation arrangements and core methodological principles. Service form can change. Whole-person care, low-barrier access, person-centred practice, TIC, Housing First values, rights-based orientation and continuity should remain intact. This distinction becomes particularly important when organisations later consider replication and scaling.

The SOLACE methodological cycle can therefore be expressed as:

Assess → Design → Implement → Monitor → Learn → Adapt.

When the model becomes more mature, the cycle continues. New evidence may lead to redesign. New partnerships may increase capacity. Changes in legislation or financing may

open possibilities that did not exist at the beginning. **Integrated care is consequently never truly "finished".**

CROSS-CUTTING CASES — Use the cases to test whether the model works as intended

Monitoring can follow the same five case pathways used during design. For **HCSOM**, the team may ask whether people reached through outreach actually connect with healthcare and remain in follow-up. For **NMP**, it may examine whether support remains flexible and accessible after housing and whether health, mental-health and social needs are addressed without undermining Housing First principles. For **HESED**, it may ask whether families who were previously distant from mainstream systems are gaining meaningful access rather than merely receiving more referrals. For **Casa Ioana**, monitoring may examine whether family pathways are safer, more coordinated and less repetitive. For **VPR**, it may track whether continuity is maintained as families move from homelessness or temporary accommodation into permanent housing. These case-based questions complement quantitative indicators by testing the lived coherence of the pathway: did the integrated model actually make the system easier and more effective to use?

14. Level 2 Summary — Bringing the Implementation Process Together

Level 2 transforms the conceptual commitments of IHSC into an operational process. The most important methodological lesson is that organisations should not begin by copying a service model. They should begin by understanding the problem their local system needs to solve. The local context reveals the population, resources and fragmentation. Needs assessment identifies the health, social and housing issues that require a response. Readiness assessment establishes the capacities and conditions already present and those that must be strengthened. Service design translates these findings into functions, entry points and partnerships. The multidisciplinary team brings together the expertise needed to respond to complexity. Care pathways turn separate services into a coherent journey. Outreach and low-threshold access connect people who would otherwise remain outside the system. Housing provides a foundation for stability and recovery. Trauma-Informed Care shapes how people experience the entire service. Digital health creates additional access routes where it provides real value. Monitoring turns daily practice into evidence. Learning allows implementation to improve. **Different SOLACE-CEE partners will therefore legitimately produce different operational models.**

HCSOM may illustrate integrated care for people using shelters and experiencing rough sleeping, with extensive healthcare infrastructure, outreach, telemedicine and remote monitoring.

Housing First Poland demonstrates how multidisciplinary and psychologically informed support can follow individuals into permanent housing and maintain Housing First fidelity.

HESED demonstrates community-based care for families and individuals living in housing instability and informal environments.

Casa Ioana demonstrates integrated support for women and families experiencing homelessness, domestic violence and severe vulnerability through coordinated social support, accommodation, healthcare and case management.

VPR demonstrates continuity from outreach and outpatient integrated healthcare into Housing First and longer-term housing-based support.

The models differ because the populations and environments differ. Their common foundation lies elsewhere:

- the person rather than the institution is at the centre;
- health, social and housing needs are addressed together;
- access responds to real barriers;
- different professions share responsibility;
- services are connected through pathways;
- continuity extends across housing transitions;
- care is trauma-informed and rights-based;
- and evidence is used to improve implementation.

This is the point at which a collection of services becomes an integrated-care model.

THE FIVE CASES AT THE END OF LEVEL 2

At the end of Level 2, the cases have moved from illustrating need to testing implementation. **HCSOM** asks whether outreach, healthcare, mental health, digital tools and follow-up can function as one pathway for a person without stable housing. **NMP** asks whether permanent housing can remain the foundation while flexible multidisciplinary support continues according to need. **HESED** asks whether integrated care can be designed around family and community realities rather than expecting marginalised households to adapt to inaccessible systems. **Casa Ioana** asks whether safety, trauma-informed practice, family support, healthcare and housing can be coordinated around a mother and children rather than delivered as disconnected interventions. **VPR** asks whether continuity can be maintained across the entire transition from severe housing exclusion through integrated outpatient care and into permanent housing. Together, the cases demonstrate the central implementation lesson of Level 2: **fidelity lies in the shared principles and functions of integrated care, while the operational form must be adapted to context.**

SOLACE-CEE Project Methodology Guidelines

LEVEL 2 — FROM PRINCIPLES TO PRACTICE

Designing and Implementing Integrated Health and Social Care

Translates principles into practical implementation steps for designing, organising and improving integrated care.

4 Understanding the Local Context

- population and housing situations
- service ecosystem and gaps
- barriers, bottlenecks and transitions
- local assets and opportunities

5 Identifying the Target Population and Assessing Needs

- define who the service is for
- assess health, social and housing needs
- combine data, professional insight and lived experience
- translate findings into priorities

6 Assessing Readiness for Integrated Care

- governance, workforce and partnerships
- financing, digital capacity and data systems
- legal and organisational conditions
- use the SCIROCCO Maturity Model as a readiness lens

7 Designing the Integrated Service Model

- define purpose, functions and target outcomes
- decide what is provided directly and via partners
- design low-barrier entry points and the Integration HUB
- create a coherent service model

8 Building the Multidisciplinary Team

- team composition and roles
- case conferences and shared language
- supervision and staff support
- clear responsibility and coordination

9 Designing Care Pathways and Ensuring Continuity

- multiple entry points and triage
- integrated care/support plans
- referrals, warm handovers and follow-up
- hospital discharge, housing transitions and continuity

10 Organising Integrated Service Delivery

- outreach and community-based support
- primary care, mental health and social work
- housing support and medical respite
- prevention, health promotion and flexible delivery

11 Embedding Trauma-Informed Care in Everyday Practice

- safety, predictability and respectful communication
- choice, boundaries and transparency
- team culture and reflective practice
- trauma-informed organisation

12 Integrating Telemedicine and Digital Health

- use technology where it adds value
- teleconsultation, telepsychiatry and remote monitoring
- consent, privacy and digital exclusion
- integrate digital tools into real care pathways

13 Monitoring, Evaluation, Learning and Adaptation

- monitor implementation and outcomes
- include lived-experience feedback
- learn from pathway failures and successes
- improve, adapt and strengthen fidelity

Implementation Cycle

Assess → Design → Implement → Monitor → Learn → Adapt

Cross-cutting cases used throughout Level 2

- **HCSOM / MALTAI** — outreach and complex needs
- **NMP** — Housing First and recovery
- **HESED** — community-based family support
- **Casa Ioana** — family-centred and trauma-informed pathways
- **VPR** — continuity from homelessness to housing

Level 2 shows how principles become service design, care pathways and everyday practice.

15. Transition to Level 3 — From Integrated Services to an Integrated Ecosystem

Level 2 answers the practical question of how an organisation can design and operate integrated care. **But the success of that service will still depend on the wider environment.** A high-quality programme may remain financially dependent on temporary grants. An effective multidisciplinary team may face regulatory barriers to information sharing. A strong hospital-discharge pathway may depend on individual personal relationships rather than institutional agreements. A Housing First programme may have excellent support but too few affordable homes. An NGO clinic may provide accessible care while public reimbursement mechanisms remain unavailable. These are no longer primarily service-design problems. **They concern the ecosystem around the service. Integrated care becomes sustainable only when partnerships, governance, financing, legislation, data systems and public policy begin to support it.** Level 3 therefore moves from the operational model to the environment that enables it. It asks:

- how partnerships become durable rather than personal;
- how innovation becomes financed rather than permanently grant-dependent;
- how data can demonstrate impact;
- how legislation can enable coordination;
- how implementation experience can influence policy;
- and how a model developed in one setting can be replicated or scaled without losing its core principles.

The progression of the PMG is therefore deliberate:

➔ Level 1 asks what integrated care is and why it matters.
➔ Level 2 asks how it is designed and implemented.
➔ Level 3 asks how integrated care becomes sustainable, transferable and capable of contributing to wider system change.

III. LEVEL 3 — FROM SERVICES TO SUSTAINABLE ECOSYSTEMS

Creating the Conditions for Sustainability, Scaling and System Change

Levels 1 and 2 focused primarily on understanding homelessness and complex needs and on designing and implementing integrated care in practice. By this stage, an organisation may already have a functioning model: a clearly defined target population, an accessible entry point, multidisciplinary cooperation, care pathways, outreach, health and social support, housing orientation, Trauma-Informed Care, digital tools where appropriate, and mechanisms for monitoring and adaptation. However, a functioning service is not yet the same as a sustainable integrated system. Integrated care can work well at programme level while remaining vulnerable to changes in funding, staff turnover, leadership, institutional priorities or local partnerships. A service may depend on one particularly committed hospital clinician, a temporary grant, a favourable municipal decision or an informal arrangement between organisations. These conditions may allow innovation to emerge, but they do not necessarily allow it to endure. This is why the **SOLACE-CEE methodology extends beyond implementation.** The Methodological Introduction explicitly recognises that sustainable change requires more than establishing individual pilot services. **Integrated care must be embedded within wider systems and supported by professional capacity, institutional cooperation, sustainable financing and enabling policy environments.** The project therefore connects service delivery with capacity building, knowledge exchange, evaluation, stakeholder engagement, replication and scaling.

Level 3 therefore asks a different set of questions: *How can cooperation become institutional rather than dependent on individuals? How can funding become stable enough to maintain services beyond a project cycle? How can legislation and public policy enable rather than obstruct integration? How can data generated in practice be converted into evidence? How can evidence influence organisational and policy decisions? Which parts of a successful model should be replicated, and which should remain locally adapted? How can a local innovation contribute to wider system change?* These questions move the methodology from the level of the individual programme to the ecosystem around it.

The progression can be summarised as:

Service → Partnership → Ecosystem → Institutionalisation → Scaling → System Change.

As with Level 2, **this process should not be interpreted as fully linear.** Partnerships influence financing. Financing affects the workforce. Data strengthen advocacy. Policy change may create new funding opportunities. Scaling may reveal new implementation barriers and require renewed adaptation. A sustainable integrated-care system develops through interaction among these dimensions.

16. Building Partnerships and Integrated Governance

Integrated care is based on a simple reality: **no single organisation can respond comprehensively to homelessness, health and social exclusion alone.** Even a large multidisciplinary organisation will depend on services beyond its direct control. Hospitals, specialist healthcare, mental-health services, addiction treatment, housing providers, municipalities, employment services, social-protection authorities, schools, legal services and community organisations all influence the pathway of people experiencing homelessness. The PMG therefore explicitly states that i**ntegrated care requires partnerships beyond the core team**, including hospitals, primary healthcare providers, mental-health services, addiction services, municipalities, public authorities, social-service providers, housing providers, employment services, educational institutions, civil-society organisations and community organisations. These partnerships should be **based on clearly defined roles, shared understanding and practical cooperation mechanisms. Partnership building should begin with the service-user pathway** rather than with organisational prestige or institutional hierarchy. **The most important partners are those whose decisions materially influence whether people can access, continue or complete care.**

CASE COMPARISON — The critical partners change with the pathway

The five cross-cutting cases show why partnership maps should not be standardised around a fixed list of institutions. For the **HCSOM case**, continuity may depend especially on connections among outreach, shelters, health centres, hospitals, mental-health services and telemedicine capacity. For the **NMP case**, the housing provider and Housing First support team must remain connected with healthcare and mental-health services after permanent housing is secured. For the **HESED family**, community-based organisations, primary healthcare, municipalities, schools and social-protection systems may be particularly important. For the **Casa Ioana family**, accommodation, healthcare, domestic-violence responses, child and family services and housing pathways need to cooperate around one family. For the **VPR case**, continuity depends on links among outreach, outpatient integrated care, hospitals, housing and longer-term support in Housing First. **The partnership map should therefore follow the person's actual pathway and identify the organisations that control its critical transition points.** For one target population, a hospital may be central because repeated admissions and unsafe discharge are major concerns. For another, housing providers may be the most important external partner. For families, schools, child-health services or domestic-violence services may become essential. For people leaving institutions, prisons or psychiatric facilities may need to be part of the pathway. **This means that partnership mapping should be functional.**

The question is not simply:

Who are the important stakeholders in homelessness?

It is:

Which organisations or authorities control critical points in the pathway of the population we support?

Once relevant actors are identified, organisations should **distinguish between different forms of cooperation.** Some cooperation may remain informal and operational. Frontline professionals may communicate directly to resolve everyday cases. Other areas require formal pathways, protocols or agreements because they involve recurrent transfers of responsibility. Strategic partnerships may need governance arrangements that clarify decision-making, accountability, financing or data. **The appropriate level of formalisation depends on the function.** Not every working relationship requires a memorandum of understanding. At the same time, critical pathways should not depend entirely on personal goodwill. This distinction is particularly important because integrated care often begins through committed individuals. A social worker knows a hospital nurse. A GP accepts referrals from an outreach team. A municipal officer helps resolve complex housing cases. These relationships can be extremely valuable during early implementation. **But if the pathway disappears when one person changes job, it has not yet become system integration.**

CASE QUESTION — Would the pathway survive staff turnover?

Each cross-cutting case can be used as a simple governance stress test. If the outreach worker, hospital contact, municipal officer, clinician or housing coordinator who currently makes the pathway work left tomorrow, would the person still receive the same coordinated response? If the answer is no, the relationship may be effective but it is not yet institutionalised. The next governance task is to convert the useful personal arrangement into an agreed organisational pathway with clear responsibilities and escalation mechanisms. **The aim should therefore be gradual movement from personal cooperation to organisational cooperation and, where appropriate, shared governance.** Integrated governance means that relevant organisations **increasingly share responsibility for the functioning of the overall pathway** rather than assessing success only within their own institutional boundaries. For example, hospital performance might conventionally be measured through clinical treatment and discharge. In an integrated-care ecosystem, the quality of discharge planning for a person experiencing homelessness also becomes relevant. A housing organisation may conventionally focus on tenancy management. In integrated care, coordination with health and social support becomes part of sustaining the tenancy. A homelessness organisation may traditionally focus on shelter or outreach. In an integrated ecosystem, it may also become an entry point into healthcare and housing pathways. **Governance therefore changes the unit of responsibility.**

The question shifts from:

Did our organisation perform its task?

to:

Did the pathway work for the person?

This requires information exchange, clear escalation mechanisms and agreed responsibilities. It may also require shared strategic forums in which organisations periodically review recurring problems rather than address each case as an isolated exception. For instance, if several people are repeatedly discharged from hospital without safe accommodation, the appropriate response should eventually move beyond case-by-case negotiation. The pattern should be analysed jointly and a discharge pathway developed. **This is where governance becomes a mechanism for system learning.** Local authorities and municipalities often have a particularly important role. They may influence housing, social-service commissioning, public health, local planning or funding. Their participation can therefore help move integrated care from an NGO initiative towards a locally embedded model. **People with lived experience should also have a role in governance.**

The broader Health Care for the Homeless approach informing SOLACE-CEE emphasises participation of service users not merely in receiving services but in programme development, monitoring and advocacy. The underlying IHSC work similarly identifies deeper consumer participation and involvement in decision-making as an area requiring development. An integrated ecosystem should therefore create structured opportunities for lived-experience input at several levels:

- individual care planning;
- service feedback;
- programme evaluation;
- service redesign;
- and, where feasible, strategic governance.

The purpose is not symbolic representation.

CASE LENS — Lived experience identifies different system failures

The **HCSOM case** may reveal why a formally available healthcare pathway remains inaccessible from rough sleeping. The **NMP case** may show what support is still required after housing. The **HESED family** may identify barriers that are visible only from within a marginalised community. The **Casa Ioana family** may reveal how fragmented procedures are experienced by women and children affected by homelessness and violence. The **VPR family** may show exactly where continuity becomes vulnerable during housing transitions. Participation therefore **adds knowledge that institutional actors cannot generate by examining their own procedures alone.** People who use services can identify system failures that may not be visible to managers or policymakers. The partner experience within SOLACE-CEE demonstrates different forms of ecosystem development. **DEDO and VPR** illustrate how housing, social support, healthcare and employment-related services can be developed across a network rather than within one legal entity. **HCSOM** illustrates integration across extensive health and homelessness infrastructure. **HESED** demonstrates the importance of community-based relationships and engagement. **Casa Ioana** shows how housing, social support, healthcare and responses to violence must be

connected around families. These examples differ organisationally, but the same principle applies:

Integration becomes sustainable when relationships between organisations are designed as part of the service model rather than treated as external support.

17. Creating a Sustainable Financing Model

Integrated care often requires organisations to invest before sustainable financing mechanisms are available. New staff may need to be recruited. Premises may require adaptation. Data systems must be developed. Outreach requires vehicles, equipment and staff time. Multidisciplinary cooperation requires coordination that may not be reimbursed through conventional service-payment mechanisms. Training and supervision also require resources. **Financial sustainability must therefore be considered from the beginning rather than at the end of a pilot.** The SOLACE-CEE project explicitly recognised this challenge and proposed diversification of funding sources for continued operation after EU funding. These included health-insurance collaboration, government funding, corporate funding, international funding, participation fees for training and in-kind contributions. It also identified the Integration HUB, outreach, training, recurrent data collection and policy-advocacy sessions as outputs that should continue after the project. The most important methodological lesson is not the specific funding mix proposed for SOLACE-CEE. **Financing arrangements differ substantially across countries. The broader lesson is that an integrated-care programme should avoid dependence on one temporary funding stream whenever possible.**

CASE COMPARISON — Financing the pathway, not only individual activities

The financing challenge looks different across the five cases because the functions required to sustain the pathway differ. For **HCSOM**, financing may need to sustain outreach, accessible healthcare, coordination and digital-health functions across an established homelessness infrastructure. For **NMP**, permanent housing must remain accompanied by flexible Housing First support and access to health and mental-health care. For **HESED**, community engagement and outreach may be essential functions even where they are not reimbursed as conventional clinical acts. For **Casa Ioana**, accommodation, family support, healthcare coordination and responses to violence may draw on different funding systems. For **VPR**, sustainability requires continuity across outreach, outpatient healthcare, social support and housing-based support. **The relevant unit for sustainability is therefore the integrated pathway, even when its individual components are financed through different mechanisms.** The first financing task is therefore **to understand the full cost of the model.** Organisations frequently underestimate the cost of integration because they calculate direct service delivery but overlook coordination.

The true cost may include:

- clinical time;
- social-work time;
- outreach;
- housing support;
- case coordination;
- MDT meetings;

- supervision;
- administrative staff;
- data systems;
- transport;
- digital infrastructure;
- training;
- partnership management;
- monitoring;
- and premises.

These components may not all generate easily billable outputs, yet they are precisely what makes integration function.

CASE QUESTION — Who pays for integration itself?

Across all five cases, some of the most important work happens between reimbursable interventions: arranging a specialist appointment, accompanying a person, coordinating discharge, holding an MDT meeting, maintaining contact after a housing move, engaging a family in the community or following up when care is interrupted. A financing model that pays only for isolated clinical or social acts can therefore leave the connective tissue of integrated care unfunded. Sustainability planning should make these coordination functions visible and cost them explicitly. Organisations should therefore distinguish between the cost of individual interventions and the cost of maintaining an integrated system. This is particularly relevant when negotiating with public funders or health-insurance systems that traditionally reimburse specific clinical acts rather than coordination and continuity. The next task is to map available funding sources. Some parts of the model may be eligible for health-insurance reimbursement. Registered social services may receive public financing through another mechanism. Housing may be financed through municipal or national programmes. EU or philanthropic grants may support innovation, evaluation or capacity building. Corporate donors may support components that public funding does not cover. Training or knowledge-transfer activities may eventually have separate financing. **An integrated programme can therefore require blended financing, with different sources supporting different components.** This can increase resilience, but it also creates management complexity. Funding streams may have different reporting requirements, eligible costs, target groups and time horizons. **The organisation must ensure that financial fragmentation does not reproduce operational fragmentation.** In other words, several funders can support one integrated model, but the programme should still function as one pathway. **Sustainability planning should also distinguish between innovation funding and routine service funding.** Grants are often appropriate for piloting, developing new models, testing digital tools or producing evidence. They are less suitable as the sole permanent financing mechanism for essential recurring services such as primary healthcare, outreach or housing support. **A mature model should progressively identify which components should be absorbed into mainstream public or insurance financing and which can remain grant-supported.**

The SOLACE-CEE project reflects this distinction by aiming to connect HUB and outreach sustainability with health insurance and government funding while using other mechanisms for training, data and policy work. **Economic evidence can strengthen this transition. Integrated care may require upfront investment, but fragmented homelessness and healthcare systems can also be expensive.** Repeated emergency-department visits, hospital admissions, crisis interventions and prolonged homelessness generate costs across several public systems.

The PMG also recommends the SOLACE-CEE Scaling Calculator as a tool intended to complement sustainability assessment by considering potential cost savings, including reduced emergency healthcare utilisation and wider economic benefits. Economic evaluation should nevertheless be used carefully. The Calculator is currently being developed and will be available in summer 2027. **The purpose of integrated care is not merely to save money.**

CASE LENS — Economic evidence should follow the relevant outcome

The outcomes worth examining will not be identical across cases. In the **HCSOM case**, reduced avoidable emergency use or improved continuity of chronic care may be important. In **NMP** and **VPR**, housing stability and reduced crisis-service use may be particularly relevant. In the **HESED case**, earlier access to preventive and primary care may matter alongside family and housing outcomes. In the **Casa Ioana case**, safe transitions and reduced recurrence of crisis may be central. **Economic evidence is most useful when it is linked to the actual pathway and outcomes the model was designed to improve. Health, housing and dignity remain rights-based objectives.** But demonstrating that improved outcomes can also reduce avoidable system costs may create a stronger case for mainstream financing. **Financial sustainability also depends on workforce sustainability.** A programme that cannot recruit or retain the required professionals may not be sustainable even if funding technically exists. Organisations should therefore consider salary competitiveness, training, supervision, workload and professional development as part of financial planning. **Infrastructure sustainability matters as well.** Premises, equipment, digital systems and vehicles all require maintenance and replacement. **Finally, organisations should conduct scenario planning.** *What happens if one funding source disappears? Which components are essential? Which can be reduced temporarily? Which must move into public financing? Which partners could absorb specific functions?* These questions help distinguish a service that survives from one that is genuinely sustainable. **Sustainable financing does not mean securing one permanent grant. It means building a financing architecture capable of supporting the essential functions of integrated care over time.**

18. Creating an Enabling Legal and Policy Environment

Integrated care operates across sectors that are often regulated separately. Healthcare, social services, housing, employment, data protection and professional practice may each be governed by different legislation and administrative systems. This can create barriers that no individual service provider can solve through better coordination alone. The PMG describes many implementation barriers as institutional, financial, legal, cultural and political rather than purely professional. It notes that integrated care often requires intersectoral negotiation, redistribution of responsibilities and long-term planning while political and budget cycles may remain short. **The first step is therefore to understand the regulatory environment.** Organisations need clarity regarding who is legally allowed to provide specific health services, what licensing is required, which professional competencies apply, how social services are regulated, what housing mechanisms exist and how data can be shared. Telemedicine may have additional requirements regarding professional responsibility, consent, documentation and data protection. **The goal is not to become a legal research organisation. It is to know which aspects of implementation depend on regulatory conditions.** Some barriers can be resolved operationally. Others require organisational agreements. Still others require policy reform. This distinction is important because it prevents frustration and clarifies the appropriate level of action. For example, if hospital discharge coordination is weak because professionals lack a shared procedure, an organisational protocol may solve the issue. If information cannot legally be shared under the current interpretation of regulations, legal analysis may be required. If reimbursement rules exclude a necessary service entirely, policy or funding reform may be needed. Correctly locating the barrier helps determine whether the response belongs in practice improvement, organisational agreement, legal interpretation or policy reform.

Integrated-care organisations should therefore learn to distinguish among:

- practice barriers;
- organisational barriers;
- regulatory barriers;
- and structural policy barriers.

Not every barrier should automatically trigger national advocacy. At the same time, persistent structural obstacles should not be repeatedly treated as individual service failures. This is one reason why advocacy is embedded within the SOLACE methodology rather than treated as unrelated external activity.

CASE LENS — The same barrier can sit at different system levels

The cases can help organisations test where a recurring problem actually belongs. If the **HCSOM case** repeatedly encounters difficulty entering mainstream healthcare, the immediate issue may be an operational referral problem, an administrative registration rule or a wider access policy. If the **NMP case** loses support after housing because funding eligibility is tied to homelessness status, the barrier is not primarily a case-management failure. If the **HESED family** cannot access services because of documentation, territorial

rules or discrimination, community outreach alone cannot fully resolve the problem. If the **Casa Ioana family** must navigate disconnected systems for violence, housing and health, formal intersectoral arrangements may be required. If the **VPR family** risks losing healthcare continuity when moving between settings or regions, regulatory and financing arrangements may need examination.

CROSS-CUTTING CASE — From repeated exception to structural evidence

A single failed referral may be an individual problem. Repeated failures affecting people in the same situation indicate something different. If people represented by the HCSOM case are repeatedly discharged to unstable accommodation, if Housing First participants represented by NMP repeatedly lose access to a service after becoming housed, or if families represented by HESED, Casa Ioana or VPR repeatedly encounter the same administrative barrier, the pattern should be documented as implementation evidence. **Advocacy begins when recurring case-level problems are translated into a clearly defined system issue and a feasible proposal for change.** The PMG makes this connection explicit. It frames advocacy as structured communication about recurring systemic gaps. If multiple people are discharged without housing coordination, the issue is no longer one difficult case; it is evidence of a structural pattern. **Legal and policy environments also influence whether integrated innovations can become mainstream.** A pilot may succeed through temporary exemptions, informal arrangements or exceptional funding. Scaling requires those practices to become compatible with standard rules. **Organisations should therefore assess early which components of the model are already supported by policy and which require change.** Policy engagement should be **evidence-informed and practical.** Rather than advocate only for broad principles, organisations can identify specific system barriers and propose implementable changes.

Examples might include:

- improved hospital-discharge protocols;
- recognition of outreach healthcare;
- reimbursement for services delivered to underserved populations;
- flexible registration rules;
- better coordination between health and housing;
- or inclusion of integrated care within homelessness strategies.

The SOLACE-CEE project explicitly included stakeholder and policy-support events intended to present findings, support collaboration with decision makers and insurance organisations, and strengthen financial viability and policy uptake. This illustrates the intended relationship between implementation and policy:

practice generates evidence; evidence identifies barriers; stakeholders interpret the evidence; policy can then change the conditions for practice.

19. Using Data, Research and Evidence for Improvement

Data is one of the most important bridges between an individual service and wider system change. Within the SOLACE-CEE project, data has two roles.

- ➔ **First, it informs initial service design.**
- ➔ **Second, it supports monitoring, learning, sustainability and replication.**

This dual function is essential. Data should not be collected only because a donor requires reporting. **An integrated-care organisation should become progressively more capable of using data for its own decisions.** The first requirement is **a clear data infrastructure.**

Organisations should know which information is necessary to understand:

- who the service reaches;
- what needs are present;
- what services are delivered;
- what referrals occur;
- whether pathways are completed;
- how housing status changes;
- what health and social outcomes are achieved;
- and where people disengage.

Data collection should be proportionate. Collecting everything that can technically be recorded can create administrative burden without improving decisions.

The question should always be:

Which information do we need in order to understand and improve the model?

Routine service data may include demographic information, housing situation, service use, referrals, clinical contacts, social-support interventions and housing outcomes. However, integrated care also requires information about coordination itself. For example: *Are referrals completed? How long do they take? How many people require accompaniment? How often are MDT meetings held? Which partners are involved? Where do pathways repeatedly fail?* These indicators help organisations evaluate integration rather than only volume. Qualitative evidence is equally important. A dataset can show that many people discontinue care after a referral. Interviews may reveal that transport is the barrier. Service numbers can show that women use a programme less frequently than men. Qualitative feedback may reveal concerns about safety or environment. A high rate of missed appointments may appear to be a behavioural problem until service users explain that appointments are issued in ways incompatible with their living circumstances. Lived experience should therefore be treated as evidence rather than anecdote.

CASE COMPARISON — What should we measure in different pathways?

A common evaluation framework can contain shared domains while still allowing indicators to reflect different implementation contexts. For **HCSOM**, useful pathway indicators may include outreach engagement, connection to healthcare, referral

completion, hospital follow-up and use of telemedicine or remote monitoring where relevant. For **NMP**, evaluation may follow housing retention, continuity of support, health and mental-health access and community integration after housing. For **HESED**, reach into the community, access to preventive and primary care, family needs and barriers to mainstream systems may be especially informative. For **Casa Ioana**, safety, family stability, coordinated referrals and movement from temporary accommodation towards sustainable housing may be important. For **VPR**, data can follow continuity across outreach, outpatient care, housing transition and longer-term Housing First support. The principle is not to create five unrelated evaluation systems. It is to combine shared IHSC outcomes with indicators that reflect the pathway each model is intended to improve.

CASE LENS — Quantitative patterns need the person's explanation

Suppose data show repeated missed appointments in the **HCSOM case**, low uptake of a service among families represented by **HESED**, disengagement after a housing move in **NMP** or **VPR**, or reluctance to use a particular pathway in the **Casa Ioana case**. The numbers identify a pattern but do not explain it. Listening to people using the service may reveal transport problems, fear, stigma, childcare responsibilities, digital barriers, unsuitable opening hours, lack of privacy or a breakdown in trust. Integrated evaluation therefore combines measurement with interpretation. Professional experience also matters. Frontline teams often notice patterns long before those patterns become statistically visible. **A mature evidence system combines quantitative data, qualitative insight, professional knowledge and research evidence. Data governance must accompany data collection.** Integrated care frequently involves sensitive information shared across professions and organisations. Consent, confidentiality, data minimisation, access permissions, retention and security therefore require clear procedures.

The SOLACE-CEE project includes a Data Management Plan (which will be parto of the final deliverables of the SOLACE-CEE project) addressing how data are collected, processed, shared, preserved and handled during and after the project. **Where several organisations share information, governance should be explicit rather than informal.** Evaluation should then move beyond reporting outputs. An organisation may reach many people without necessarily improving access or outcomes. The PMG recommends evaluating reach and engagement, service accessibility, client experience, health outcomes, mental-health outcomes, housing stability, service utilisation, multidisciplinary cooperation, professional capacity and system-level effects. Both quantitative and qualitative information should be used.

This creates several levels of evidence.

- Output evidence asks what the programme delivered.
- Outcome evidence asks what changed for people.
- Implementation evidence asks how and why the model functioned.
- System evidence asks whether the wider environment changed.
- Economic evidence adds another perspective by examining resource use and potential savings or efficiencies.

The final step is **knowledge translation.** Evidence that remains inside an internal database does not change systems. **Organisations need the capacity to transform data into forms appropriate for different audiences.** Frontline teams may need operational dashboards. Managers may need implementation summaries. Funders may require outcomes and financial information. Municipalities may need local service-gap analysis. Policymakers may respond to concise evidence about structural barriers. Researchers may need more rigorous evaluation datasets. People with lived experience should receive understandable information about what has been learned from their participation.

Knowledge translation therefore asks not only:

What do we know?

but:

Who needs to know it, in what form, and for what decision?

This is how an organisation moves towards becoming **evidence-informed** rather than merely data-producing.

CROSS-CUTTING CASE — Turning cases into learning without reducing evidence to stories

Cross-cutting cases can support knowledge translation by showing what aggregated findings mean in practice. A case can illustrate how a referral gap, housing transition or access barrier unfolds over time, while quantitative data demonstrate whether the same pattern affects a wider group. Used together, case-based learning and programme data can make implementation evidence understandable without treating individual stories as substitutes for systematic evaluation.

20. Scaling, Replication and System Change

The final stage of the methodology concerns what happens when an integrated-care model demonstrates value. **A successful pilot creates a new challenge.** *Should the programme expand? Should it be replicated elsewhere? Which parts should remain unchanged? Which components need adaptation? Can the model become part of mainstream systems? What evidence is sufficient to justify scale?*

The SOLACE-CEE project explicitly includes replication and scaling as core ambitions. It envisages initial implementation in five countries, further replication within the CEE region and later transfer to other European contexts. The project proposes network expansion, knowledge exchange, capacity building and methodological guidelines as mechanisms for supporting this process. The PMG reinforces an important principle: replication should transfer principles, processes, tools, competencies, implementation lessons and evaluation methods, rather than simply reproduce one organisational structure. This distinction is central to the PMG.

CASE COMPARISON — What should and should not be copied?

The five SOLACE-CEE cases make this distinction concrete. Replicating the **HCSOM** approach does not mean reproducing Hungary's homelessness infrastructure elsewhere; it means learning how outreach, healthcare, specialist access and digital tools can be connected around people experiencing rough sleeping and shelter homelessness. Replicating **NMP** does not mean copying one team structure; it means preserving Housing First fidelity, separation of housing and support, and continuity after permanent housing. Replicating **HESED** does not mean reproducing one community programme; it means adapting integrated care to families and people whose housing exclusion and healthcare barriers are shaped by community and structural conditions. Replicating **Casa Ioana** does not mean copying a shelter; it means carrying forward coordinated, trauma-informed and family-sensitive pathways linking safety, health, social support and housing. Replicating **VPR** does not mean duplicating one HUB; it means preserving continuity from homelessness and outreach through integrated healthcare and social support into permanent housing. **The transferable element is therefore the methodological function and principle. The organisational form remains context-dependent.** A clinic model developed in one city may not be appropriate in another. A Housing First pathway may depend on different housing arrangements. A telemedicine solution may be highly valuable in a region with scarce specialists but unnecessary where specialist services are readily available. A multidisciplinary team may be employed within one organisation in one context and created through contractual partnerships in another. **Replication should therefore begin by identifying the core principles and operating principles, practice approaches and enabling mechanisms of the methodology.** These include:

- **Whole-Person Integrated Care**
- **Low-Barrier and Equitable Access**
- **Trust-Based and Trauma-Informed Practice**

- **Health and Housing as Rights – System Responsibility**

These elements represent fidelity. The organisational arrangements through which they are achieved represent adaptation. Successful replication requires both.

Too little adaptation can produce a model that does not fit the local system. Too much adaptation can remove the mechanisms that made the model effective. A replication process should therefore repeat much of the earlier methodological cycle. The new location should again understand its local context, identify needs, map existing services, assess readiness and design an appropriate local version. Replication is not the final step of a completed cycle.

CASE PATHWAY — Re-running the methodology in a new context

A new organisation should not begin by selecting one of the five cases and reproducing it. It should begin again with context, population, needs and readiness, then use the cases to ask what comparable implementation problem has been solved elsewhere and which principles or tools may be transferable. In this way, the cases become implementation references rather than templates. It is the beginning of a new one. **Scaling also requires different capacities from piloting.** A small pilot can sometimes operate through informal communication and exceptional staff commitment. A larger programme requires standard procedures, leadership structures, workforce development, data systems, stable financing and stronger governance. What worked for fifty service users may not work for five hundred without organisational redesign. **This is why maturity assessment remains relevant during scaling.** The SCIROCCO perspective can be revisited to ask whether governance, workforce, digital systems, evaluation, funding and organisational capacity have matured sufficiently to support expansion. **Institutionalisation represents another stage.** A service becomes more sustainable when integrated practices are no longer perceived as an exceptional project but become part of routine organisational or public-service structures. This may involve:

- formal commissioning;
- public reimbursement;
- municipal or regional funding;
- integration into strategic plans;
- recognised professional roles;
- institutional protocols;
- or inclusion in national policy.

Institutionalisation does not necessarily mean that the government must operate the service directly. It means that the model becomes recognised as a legitimate and sustained part of the service system. Advocacy plays a central role in this transition.

The PMG frames advocacy not primarily as public campaigning but as structured communication about system gaps, supported by evidence. Professionals and organisations can document recurring barriers, preventable admissions, unmet needs, failed discharge pathways or cost inefficiencies and convert these patterns into proposals for change. This means that advocacy can begin with frontline observation. When a

recurring problem is documented, analysed and communicated through appropriate channels, practice becomes evidence. Professional leadership is also important. **System change is not limited to people with formal authority.** A clinician can initiate a discharge protocol. A social worker can identify a recurring eligibility problem. A manager can convene an intersectoral working group. A researcher can demonstrate a service gap. A person with lived experience can identify a barrier invisible to professionals. A municipality can incorporate a successful pathway into local strategy. System change emerges through the accumulation of these actions.

FIVE CASES — From individual pathways to system change

The **HCSOM case** can turn recurring barriers between rough sleeping, shelters and healthcare into evidence for more accessible health pathways. The **NMP case** can demonstrate why permanent housing and continuing support need to be financed and governed together. The **HESED case** can make visible structural barriers affecting communities that conventional homelessness systems may overlook. The **Casa Ioana case** can reveal the need for stronger coordination across homelessness, domestic violence, family support, health and housing. The **VPR case** can demonstrate why continuity should extend across outreach, outpatient integrated care and Housing First rather than being tied to one service setting. **When these recurring pathway lessons are documented, evaluated and communicated, case-level practice becomes a source of system evidence.**

The SOLACE-CEE project includes dedicated policy-advocacy sessions intended to become recurrent forums for dialogue between policymakers and experts. This reflects the final methodological transition:

- from individual cases;
- to implementation learning;
- to evidence;
- to stakeholder dialogue;
- to institutional and policy change.

The ultimate ambition is broader than improving one programme. The Methodological Introduction explicitly frames SOLACE-CEE as **contributing to a transformation from fragmented interventions towards integrated systems of care, from crisis responses towards prevention and early intervention, and from isolated initiatives towards sustainable models capable of adaptation, replication and scaling.** For homelessness services, this also creates an important strategic distinction. The long-term goal is not to build increasingly sophisticated systems for managing homelessness indefinitely. **It is to build systems capable of ending homelessness, while providing the integrated support necessary to make housing, health and recovery sustainable. Housing-led and Housing First principles are therefore critical even at system level.** If healthcare and social services improve but people remain trapped in shelters or transitional systems indefinitely, integration has addressed only part of the problem. Similarly, if people obtain housing but lose the healthcare and support necessary to sustain it, the housing intervention remains incomplete. **System change means aligning these dimensions.**

Level 3 — Bringing the Ecosystem Together

Level 3 expands the unit of analysis.

- ➔ Level 1 focused on the person and the conceptual foundations of care.
- ➔ Level 2 focused on the service model and implementation pathway.
- ➔ Level 3 focuses on the conditions around the service that determine whether integration can survive and influence the wider system.

Partnerships convert isolated organisations into a functional ecosystem. Governance creates shared responsibility. Sustainable financing allows innovation to continue beyond project funding. Legal and policy environments determine which integrated practices can become routine. Data converts service experience into evidence. Evaluation distinguishes activity from impact. Knowledge translation makes evidence usable. Replication transfers learning without blindly copying organisational structures. Scaling increases reach while testing organisational maturity. Institutionalisation moves successful practices from exceptional projects towards standard systems. Advocacy translates recurring implementation barriers into structural questions. Policy change alters the conditions within which future services operate. These elements reinforce each other.

THE FIVE CASES AT ECOSYSTEM LEVEL

At Level 3, the cross-cutting cases no longer function mainly as illustrations of individual care. They become tests of whether the surrounding ecosystem can sustain the pathway.

For **HCSOM**, the question becomes whether cooperation among outreach, homelessness services, healthcare and digital-health functions is institutionally supported and sustainably financed. For **NMP**, it becomes whether Housing First fidelity and continuing multidisciplinary support can survive beyond pilot or project funding. For **HESED**, it becomes whether community-based access can be connected to mainstream systems rather than remain a parallel response. For **Casa Ioana**, it becomes whether the institutions responsible for safety, health, family support and housing can share responsibility around families. For **VPR**, it becomes whether continuity across homelessness, integrated outpatient care and permanent housing can be embedded in financing, governance and public systems. **The ecosystem is sustainable when these pathways no longer depend primarily on exceptional effort or temporary arrangements.** Strong partnerships create better pathways and better data. Better data strengthen advocacy. Advocacy can influence financing and regulation. Improved financing supports workforce and continuity. Greater maturity enables scaling. Scaling produces further evidence. The methodology therefore continues to function as a learning cycle even at system level. A useful way to understand this progression is:

Local problem → Integrated response → Evidence → Partnership → Institutionalisation → Replication → System change.

The process does not imply that every NGO must become a national policy organisation. Different actors will influence different levels of the system. A frontline team may improve

a local pathway. An organisational leader may institutionalise a partnership. A municipality may redesign commissioning. A national authority may change regulation. A European network may spread evidence across countries. The PMG therefore encourages organisations t**o identify their realistic sphere of influence while recognising that integrated care inevitably reveals system-level barriers that require action beyond individual service delivery.**

SOLACE-CEE Project Methodology Guidelines

LEVEL 3 — FROM SERVICES TO SUSTAINABLE ECOSYSTEMS

Creating the Conditions for Sustainability, Scaling and System Change

Moves from service delivery to partnerships, financing, policy, evidence and long-term system change.

16 Building Partnerships and Integrated Governance

- Identify critical partners across the pathway
- Define roles, agreements and escalation routes
- Build shared accountability and governance
- Include lived experience in partnership learning

17 Creating a Sustainable Financing Model

- Understand the full cost of integration
- Combine health, social, housing and project funding
- Plan for workforce and infrastructure sustainability
- Use economic evidence to support sustainability

18 Creating an Enabling Legal and Policy Environment

- Identify practice, organisational and regulatory barriers
- Improve information sharing and coordination
- Connect service evidence with advocacy
- Support policy change for integrated care and housing

19 Using Data, Research and Evidence for Improvement

- Build a useful data and evaluation framework
- Track outputs, outcomes, implementation and system effects
- Combine quantitative, qualitative and lived-experience evidence
- Translate evidence into practical learning

20 Scaling, Replication and System Change

- Distinguish core principles from local adaptation
- Treat replication as a new implementation cycle
- Support institutionalisation and mainstream uptake
- Move from local implementation to system change

Ecosystem Progression

Local problem → Integrated response → Evidence → Partnerships → Institutionalisation → Replication → System change

The cross-cutting cases at ecosystem level

HCSOM / MALTAI | NMP | HESED | Casa Ioana | VPR

The same cases show how individual pathways generate system learning and evidence.

Core message

- Integration is a direction, not a finished state
- Housing remains the foundation
- Relationships are infrastructure
- Learning should be built into implementation
- Sustainability starts before the project ends

Level 3 connects integrated services with sustainable ecosystems and the long-term goal of ending homelessness.

Conclusion of the Three-Level Methodology

The three levels of the PMG should be understood as one connected methodology rather than three separate themes.

Level 1 — **Conceptual Foundations** establishes the values and understanding necessary for integrated care. Homelessness is multidimensional and dynamic; health, housing and social needs interact; people should be treated with dignity and agency; and access, trust, rights and system responsibility are central.

Level 2 — **From Principles to Practice** translates these commitments into an implementation process. Organisations understand the local context, assess needs and readiness, design an appropriate model, build teams and pathways, organise service delivery, embed Trauma-Informed Care and digital health, monitor implementation and adapt.

Level 3 — **From Services to Sustainable Ecosystems** addresses the wider conditions that allow successful implementation to last and spread. Partnerships, governance, financing, legislation, evidence, institutionalisation, replication, scaling and policy change connect local implementation to broader structural reform.

Together, the levels create the overall SOLACE-CEE methodological pathway.

THE CROSS-CUTTING CASES ACROSS ALL THREE LEVELS

The five cases have deliberately moved through the PMG together with the methodology. In Level 1, they helped explain why integrated care is needed by showing different forms of homelessness, housing exclusion, complex need and barriers to access. In Level 2, they illustrated how the same principles lead to different service designs, teams, pathways, access strategies and implementation arrangements. In Level 3, they show that the durability of those pathways depends on partnerships, governance, financing, regulation, evidence and institutionalisation. Their purpose is therefore not to present five ideal models. Together they demonstrate the central SOLACE-CEE proposition: c**ommon principles can guide integrated care across very different contexts, but implementation must remain responsive to the population, local system and pathway being addressed.**

UNDERSTAND → DESIGN → IMPLEMENT → CONNECT → LEARN → SUSTAIN → SCALE → CHANGE THE SYSTEM.

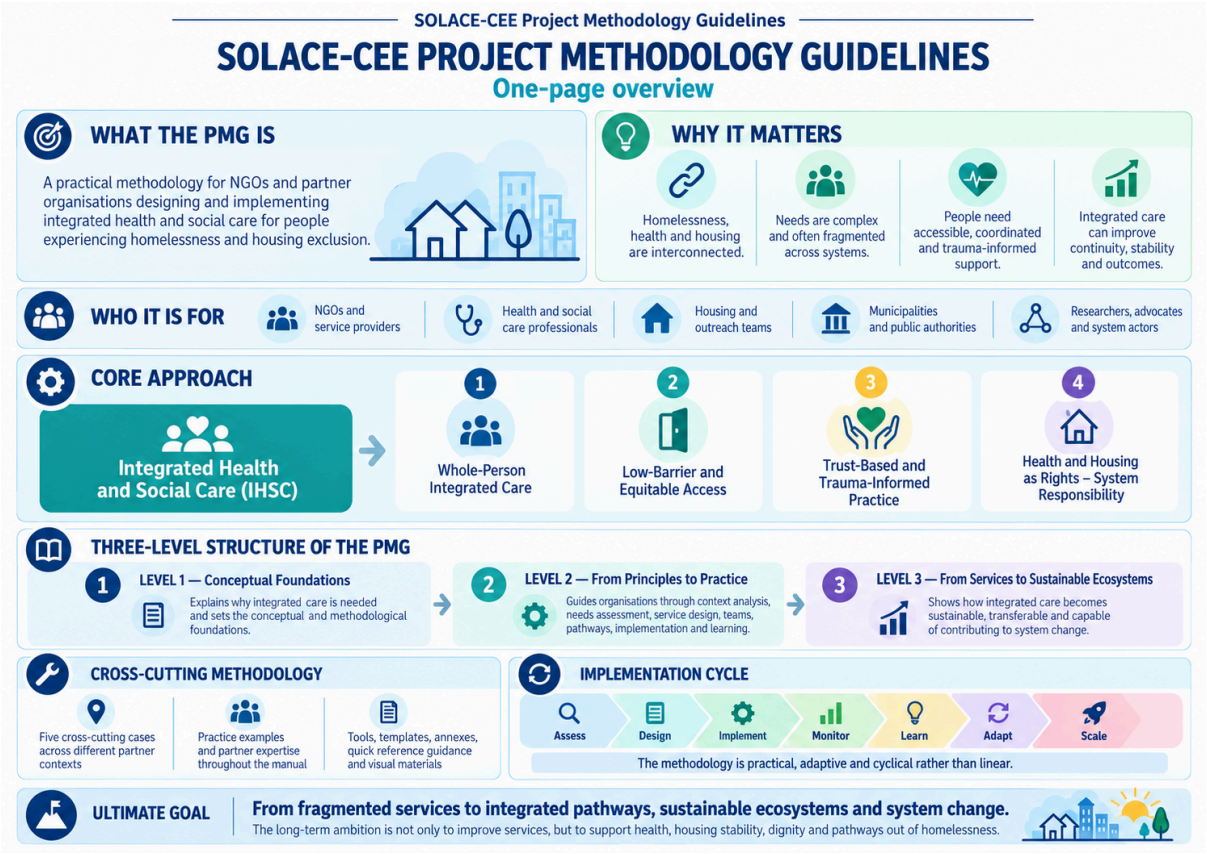
Yet the process remains **cyclical.**

- **Scaling into a new region requires renewed assessment.**
- **Policy change creates new implementation opportunities.**
- **Evaluation may reveal weaknesses in the service model.**
- **New populations may require different pathways.**

The methodology therefore returns continuously to its foundational cycle:

Assess → Design → Implement → Monitor → Learn → Adapt → Scale.

The final objective is not organisational growth for its own sake. Nor is it the permanent creation of parallel specialist systems for people experiencing homelessness. **The aim is to contribute to service systems that become progressively more accessible, coordinated, equitable, housing-oriented and capable of responding to people as whole persons.** In this sense, integrated care is both a service methodology and a strategy for system transformation. The success of the SOLACE-CEE approach should ultimately be judged not only by how many integrated services are created, but by whether those services help build systems in which fewer people are excluded from healthcare, fewer people become lost between institutions, housing transitions are more sustainable, local systems learn from evidence, and homelessness is increasingly addressed through permanent housing and coordinated support rather than repeated crisis management.



CONCLUSION

From Integrated Care to Ending Homelessness

The Project Methodology Guidelines began with a simple observation: people experiencing homelessness rarely face one isolated problem, yet the systems designed to support them are commonly organised as if they did. Housing, physical health, mental health, trauma, substance use, income, employment, family relationships, legal status and access to services interact continuously. When these needs are addressed through disconnected institutions, people are expected to perform the integration themselves. Those with the greatest needs are therefore often required to navigate the most fragmented and difficult pathways.

SOLACE-CEE was developed as a response to this mismatch. Its methodology is based on the principle that services should be organised around people and their pathways rather than around institutional boundaries. The PMG translates this into a coherent set of principles: whole-person care, person-centred practice, Housing First values, Trauma-Informed Care, structured needs assessment, data-informed design, accessible integrated entry points, outreach, multidisciplinary cooperation, clear referral pathways, continuity across housing transitions, digital health where it adds value, partnerships, professional capacity building, continuous learning, sustainability, replication and system change.

These Guidelines have organised that methodology into three interconnected levels.

Level 1 — Conceptual Foundations established why integration is necessary. Homelessness was understood not as a fixed individual identity but as a multidimensional and dynamic condition shaped by housing, health, social circumstances and structural environments. Health and social needs were considered together, and four core principles provided the common foundation for the methodology: Whole-Person Integrated Care; Low-Barrier and Equitable Access; Trust-Based and Trauma-Informed Practice; and Health and Housing as Rights – System Responsibility.

Level 2 — From Principles to Practice translated these foundations into implementation. Organisations were guided to understand the local context, identify the target population, assess needs, evaluate readiness, design the integrated model, establish multidisciplinary cooperation, build care pathways, organise delivery across outreach, outpatient, community and housing settings, embed Trauma-Informed Care and digital health, and use monitoring and feedback to continuously improve the programme. This reflects the SOLACE Methodological Cycle, which progresses from understanding context and needs through implementation, evaluation, adaptation, sustainability and ultimately replication and policy change.

Level 3 — From Services to Sustainable Ecosystems moved beyond the boundaries of the individual programme. It addressed the conditions that determine whether integrated care

can continue, mature and influence the wider system: partnerships and governance, sustainable financing, enabling legal and policy environments, data and evidence, institutionalisation, replication, scaling and advocacy.

Together, the three levels reinforce one central message:

Integrated care is not a single service, building or organisational structure. It is a way of organising systems around the needs and pathways of people.

Integration is a direction, not a finished state

One of the most important lessons of the SOLACE-CEE approach is that integration should not be treated as a binary condition. A system is rarely simply integrated or fragmented. Integration develops along a continuum. Organisations may begin with informal cooperation, progress towards structured referrals and multidisciplinary working, and later develop shared governance, sustainable financing and more mature integration with mainstream systems.

The PMG frames integration **as structural maturity** rather than simple co-location. Integrated care requires defined roles, shared accountability, continuous monitoring and a long-term stabilisation focus. For organisations using this manual, this has an important practical implication: **it is not necessary to build everything at once.** A service can begin with one important fragmentation point. A hospital and homelessness organisation can establish a discharge pathway. An outreach programme can connect people systematically to primary healthcare. A Housing First team can strengthen mental-health coordination. A shelter can introduce regular healthcare. A municipality can establish an intersectoral coordination mechanism. An NGO can begin collecting evidence about recurring gaps. Each improvement can create the foundation for the next. Integrated care advances when these changes gradually become connected. The methodology is therefore deliberately cyclical:

Assess → Design → Implement → Monitor → Learn → Adapt → Scale.

This cycle should continue throughout the life of the programme. Implementation creates information that may change the service design. New partnerships can make additional interventions possible. Evaluation can reveal unintended barriers. Changes in policy or funding may open opportunities for integration that were previously unavailable. **The methodology should evolve as the system matures.**

Maintain fidelity to principles while adapting implementation

SOLACE-CEE does not provide a replication recipe. This is intentional. The PMG follows a broader implementation logic also used in Housing First: fidelity should be maintained to core principles, while organisational and operational arrangements are adapted to local contexts. This distinction is essential for the future use of the PMG. The organisation applying these Guidelines should preserve the core orientation: whole-person understanding; person-centred and rights-based care; Housing First values; Trauma-Informed Care; low-barrier and equitable access; multidisciplinary cooperation; continuity; data-informed implementation; participation; learning and adaptation. But the way these principles are operationalised may differ. An integrated entry point may be a

dedicated HUB in one city, a shelter-based programme in another, a mobile team in a third, or a coordinated network of providers elsewhere. Healthcare may be delivered directly by an NGO, embedded through partnership or connected through mainstream services. Telemedicine may be essential in one context and peripheral in another. Housing may be directly provided, accessed through a social rental agency, or organised through municipal partnerships. These differences do not weaken the methodology. They demonstrate its adaptability.

The PMG defines local adaptation as a core requirement and identifies national legislation, healthcare financing, social-protection systems, housing availability, existing homelessness services, workforce capacity, digital infrastructure and local epidemiological and social conditions as factors that should influence implementation. The practical task is therefore to distinguish between what must remain true and what may change.

Housing remains the foundation

Although these Guidelines focus on Integrated Health and Social Care, they should never be interpreted as suggesting that increasingly sophisticated health and social services can substitute for housing. They cannot. **Housing remains central.** The SOLACE-CEE project incorporates Housing First values precisely because housing is understood not only as an outcome but as a foundation for health, recovery and social integration. The underlying Health Care for the Homeless work similarly emphasises that "housing is health care" and that the ultimate purpose of comprehensive support is to help people stabilize their lives and move out of homelessness. **Integrated health and social services should therefore contribute to a pathway towards permanent housing wherever homelessness is present.** Outreach should not become a permanent system for making street homelessness more manageable. Shelter-based healthcare should improve health while also supporting pathways out of temporary accommodation. Medical respite should create a safe bridge between hospital and the next appropriate setting, not become another form of long-term institutional accommodation. Housing support should not end when somebody receives a key. And healthcare should not disappear once a person is formally housed. The relationship between housing and support is therefore bidirectional.

- ➔ **Housing makes health and recovery more achievable.**
- ➔ **Health and social support make housing more sustainable.**

This is why continuity of care across housing transitions is explicitly included in the Backbone. Moving into stable housing should not automatically result in the loss of established therapeutic or social relationships.

Do not create a better parallel system and stop there

Targeted services for people experiencing homelessness are often necessary because mainstream systems are currently inaccessible. Outreach, specialised clinics, Integration HUBs, supported telemedicine, medical respite and multidisciplinary homelessness teams can correct serious access failures. However, **the long-term ambition should not be the permanent development of two separate systems:** one for the general population and another for people experiencing homelessness. **Integrated care should also create**

bridges into mainstream services and help those services become more accessible. This requires a balance. Specialised responses are needed when mainstream systems cannot adequately respond to complexity or exclusion. At the same time, **specialised services should not unintentionally reinforce segregation.** An Integration HUB is therefore best understood as **an accessible gateway into a wider system,** not as an isolated alternative healthcare system. This is exactly how the PMG defines its role. Over time, integrated programmes should ask:

- *Which specialist functions remain necessary?*
- *Which mainstream services have become accessible?*
- *Which pathways can be transferred?*
- *Which barriers should now be addressed at system level?*

The maturity of an integrated programme is partly reflected in its ability to influence the wider system around it.

Relationships are infrastructure

Many of the most important elements of integrated care are not buildings, equipment or clinical procedures. They are relationships. A trusted outreach worker can create access where a formal system has failed. A case manager can maintain continuity across institutions. A GP who understands homelessness can prevent repeated emergency care. A housing worker who communicates with healthcare providers can help stabilise a tenancy. A hospital discharge coordinator can prevent a return to the street. A municipal partner can transform an informal arrangement into an institutional pathway. People with lived experience can identify barriers that professionals have normalised. These relationships should not be treated as soft or secondary components of implementation. They are part of the infrastructure of integrated care. The challenge is to gradually make them less dependent on particular individuals by embedding them in protocols, multidisciplinary routines, governance structures, professional training and organisational culture. This transition—from relationship to structure without losing the quality of the relationship—is one of the key tasks of mature integrated care.

Trauma-Informed Care should become organisational culture

The same principle applies to Trauma-Informed Care. TIC should not remain an isolated training topic. The PMG treats it as a cross-cutting principle that should be embedded throughout the service system. Services should promote physical and psychological safety, trust and predictability, avoid re-traumatisation, recognise the effects of trauma on behaviour and participation, and strengthen agency and meaningful involvement in decisions. For organisations, maturity therefore means moving from:

staff who know about trauma

to

services designed around trauma-informed principles

and ultimately to

organisations whose leadership, procedures and partnerships reinforce those principles.

This includes how assessments are conducted, how rules are communicated, how conflict is managed, how information is shared, how environments are designed and how staff themselves are supported. Worker wellbeing is also part of system responsibility. The IHSC eLearning notes that repeated crisis, relapse and scarcity can contribute to moral fatigue, emotional exhaustion and defensive practice, while integrated care requires shared responsibility, supervision, reflective practice and boundary clarity. A sustainable integrated system therefore needs to care for the workforce that sustains it.

Use data to make the invisible visible

One of the recurring problems identified in the SOLACE-CEE project is that homelessness and health systems frequently operate with incomplete data. Without evidence, recurring system failures can appear to be isolated cases. One missed referral is an individual event. Twenty similar missed referrals indicate a pathway problem. One hospital discharge into homelessness may be treated as an exception. Repeated discharge into homelessness becomes a system-level issue. One client unable to access care because of registration rules may be resolved through individual advocacy. A recurring pattern indicates a structural barrier. Data allows organisations to make this transition from anecdote to evidence.

The PMG therefore positions data throughout the methodological cycle: in needs assessment, service design, monitoring, evaluation, sustainability and replication. It explicitly states that monitoring information should inform continuous adaptation and that evidence generated through implementation should ultimately be translated into policy recommendations, stakeholder action plans, professional guidance, advocacy messages, training resources and replication tools. This is also why quantitative and qualitative evidence must be combined. Numbers show patterns. People explain what those patterns mean. Professional experience identifies operational realities. Research places local findings within a wider evidence base. Together, they create a stronger foundation for organisational and policy decisions.

Learning should be built into implementation

The PMG itself reflects a learning process. The SOLACE methodological cycle begins with understanding local context and needs, moves into design and implementation, and then explicitly returns to feedback, evaluation, adaptation, sustainability and replication. This means that implementation teams should not regard changes to the original programme design as inherently problematic. If new evidence demonstrates that the service should change, adaptation is appropriate. The important question is whether the adaptation preserves the core principles and improves the response to the target population. Continuous learning can occur at several levels. Individual practitioners learn from cases. Teams learn through multidisciplinary reflection. Organisations learn from monitoring. Partners learn from recurring pathway failures. Regions learn through evaluation. Countries learn through replication. International networks allow lessons to move between contexts. This is how a pilot becomes a methodology rather than simply a project.

Sustainability starts before the project ends

A common weakness of social innovation is that sustainability is considered only when pilot funding approaches its end. The SOLACE-CEE project deliberately takes a different approach. It identifies Integration HUBs, outreach, training, recurring data collection and policy-advocacy mechanisms as outputs to be maintained and proposes diversified financing involving health insurance, public funding, corporate sources, international funding and other mechanisms. The specific funding solutions will differ by country. The methodological principle is stable:

If an intervention addresses an ongoing need, its long-term financing should be considered part of implementation rather than an afterthought.

The same applies to workforce, infrastructure, partnerships and organisational ownership. A model is not sustainable merely because the intervention works. It becomes sustainable when the conditions necessary for delivering it can also continue.

Replication is a new implementation process

The success of one local model does not mean that its organisational structure should be reproduced elsewhere. Replication should instead transfer the knowledge generated through implementation. There are six categories that should be transferred: principles, processes, tools, competencies, implementation lessons and evaluation methods. It explicitly distinguishes these from the specific organisational structure, which should be adapted locally. The PMG itself was envisaged as a practical guide for NGOs working in homelessness to establish and implement integrated health and social services, while replication activities were intended to support adaptation first across the CEE region and later in other European contexts. Replication therefore restarts the methodological cycle.

A new organisation should again:

- understand its population;
- map services and gaps;
- assess needs;
- assess readiness;
- engage stakeholders;
- design the local model;
- implement;
- monitor;
- and adapt.

The PMG can shorten the learning curve. It cannot replace local learning.

From local implementation to system change

The ultimate ambition of the methodology extends beyond service improvement. The final principle is explicit: **integrated care should contribute to structural change in how homelessness and health inequalities are addressed. Implementation evidence should become a bridge between local innovation, professional practice and policy development**.

System change can occur in many forms. A hospital introduces a formal discharge protocol. A municipality aligns housing and health objectives. A health insurer reimburses outreach care. A social-service regulation incorporates integrated practice. Housing support becomes separated from treatment compliance. Data systems begin measuring continuity rather than only isolated service activity. People with lived experience obtain a formal role in programme governance. Integrated-care training becomes part of professional development. A pilot service becomes part of mainstream financing. National homelessness policy adopts housing-led and integrated-care principles. None of these changes alone transforms the system. Together, they can shift their direction.

The IHSC approach to homelessness is both problem-focused and principles-driven, grounded in human rights and in a system-change paradigm that requires services to adapt to people's needs rather than expecting people to adapt to services. This principle provides perhaps the clearest summary of the PMG.

The system should increasingly follow the person, rather than requiring the person to follow the system.

The role of different actors

No single actor can deliver system change alone. The PMG makes this explicit. Clinical professionals can identify discharge gaps. Social workers can document structural barriers. Managers can formalise cooperation. Municipal actors can align funding and governance. Researchers can generate evidence and translate it into policy. Each role contains different leverage points, and implementation becomes cumulative when these actions reinforce one another. This means that the PMG should not leave the reader with the impression that an NGO is responsible for reforming the entire system. An organisation should instead identify its sphere of influence.

- *What can the team change?*
- *What can organisational leadership change?*
- *What requires partnership?*
- *What requires a municipality?*
- *What requires national policy?*
- *Which evidence would make the next level of change possible?*

This approach makes system change more realistic. It turns broad ambition into a sequence of actionable improvements.

A Final Implementation Perspective

For an organisation opening this manual for the first time, the scale of integrated care may initially appear daunting. Integrated care can involve healthcare, social support, housing, mental health, outreach, case management, data, digital health, financing, legislation and partnerships. But organisations should not interpret the PMG as a requirement to create all of these elements immediately. The practical starting point is smaller:

➔ Understand the population.
➔ Identify the most important fragmentation.

- ➔ Find the part of the pathway where your organisation can create meaningful improvement.
- ➔ Build the partnerships necessary to address it.
- ➔ Implement according to the core principles.
- ➔ Collect evidence.
- ➔ Learn.
- ➔ Improve.
- ➔ Then expand the integration where it adds value.

This is consistent with the SOLACE-CEE cycle itself. The project methodology does not move directly from needs assessment to system reform. It progresses through design, implementation, capacity building, monitoring, evaluation, adaptation and sustainability before reaching replication and policy change. Integrated care is therefore ambitious, but it is also incremental. Small structural changes can matter. A warm handover instead of passive referral. A regular MDT meeting instead of parallel case management. A hospital discharge call instead of uncoordinated release. An outreach consultation instead of waiting for clinic attendance. Continued support after housing instead of case closure. A lived-experience consultation instead of designing services only from professional assumptions. A shared indicator instead of separate organisational reporting. A formal partnership instead of dependence on individual goodwill. Each change reduces fragmentation. When these improvements become connected and institutionalised, they begin to form an integrated system.

The Direction of Travel

The PMG ultimately proposes a direction of travel rather than a fixed endpoint.

- From fragmented services → to coordinated pathways.
- From crisis response → to prevention and continuity.
- From service-centred systems → to person-centred care.
- From conditional support → to rights, choice and Housing First values.
- From trauma-unaware environments → to trauma-informed organisations.
- From referral → to shared responsibility.
- From isolated professional expertise → to multidisciplinary cooperation.
- From activity reporting → to evidence-informed learning.
- From temporary projects → to sustainable models.
- From local innovation → to replication and system change.

And, most importantly:

- **from managing homelessness → to ending homelessness through permanent housing and the support required to sustain it.**

This direction captures the ultimate purpose of SOLACE-CEE. The project was designed to provide comprehensive multidisciplinary support that addresses immediate health needs while also tackling the wider conditions affecting wellbeing, with the aim of helping people stabilize their lives and ultimately move out of homelessness. The PMG translates that ambition into a practical methodology. It does not assume that one model will solve

homelessness. It proposes that organisations and systems can become progressively better at responding when they: understand complexity; organise around people; remove barriers; connect health, social care and housing; maintain continuity; learn from evidence; work across institutional boundaries; and use implementation experience to change the conditions that repeatedly create exclusion.

Closing Message

Integrated Health and Social Care is not simply about bringing more professionals into homelessness services. It is about changing how responsibility is organised. It asks services to stop treating fragmentation as the individual's problem. It asks health professionals to recognise housing and social conditions as part of the care context. It asks social and housing systems to recognise health as part of stability. It asks organisations to build pathways rather than isolated interventions. It asks systems to learn from the people who use them. And it asks successful innovations to look beyond their own survival towards the structural conditions that determine whether the same problems will continue to recur. The final measure of success is therefore not whether an organisation can say that it operates integrated care. The more important questions are:

- *Can people reach the support they need?*
- *Do they experience services as connected rather than fragmented?*
- *Does support remain available when their circumstances change?*
- *Does permanent housing become achievable and sustainable?*
- *Does implementation produce learning?*
- *Does that learning improve the wider system?*

If the answer to these questions becomes progressively more positive, integration is doing what it is intended to do. And if integrated care contributes to fewer people becoming trapped in repeated cycles of crisis, hospitalisation, temporary accommodation and homelessness—and to more people gaining and sustaining permanent housing—then it becomes more than a service model. It becomes part of a strategy for ending homelessness.

Annexes

ANNEX 1 - SOLACE-CEE IMPLEMENTATION WORKBOOK

ANNEX 2 - FROM SURFACE TO SUSTAINABLE ECOSYSTEM TOOLKIT

ANNEX 3 - SOLACE-CEE PMG Quick Reference & Visual Guide

ANNEX 4 - HCSOM Case Study

ANNEX 5 - NMP Case Study

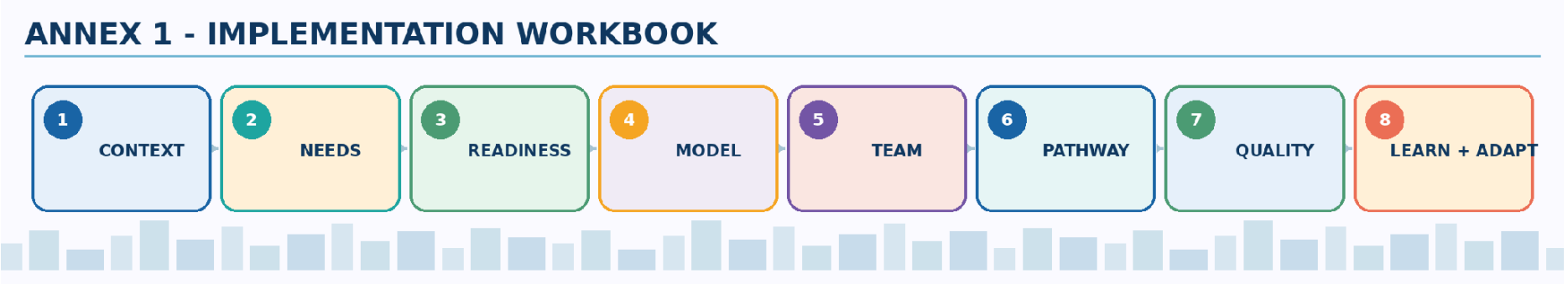
ANNEX 6 - HESED Case Study

ANNEX 7 - CI Case Study

ANNEX 8 - VPR Case Study

ANNEX 1 — SOLACE-CEE IMPLEMENTATION WORKBOOK

From context to integrated care



PURPOSE | Translate Level 2 of the PMG into a compact set of working tools for planning, implementation and review. Use the tools sequentially when developing a new model, or selectively when strengthening an existing one.

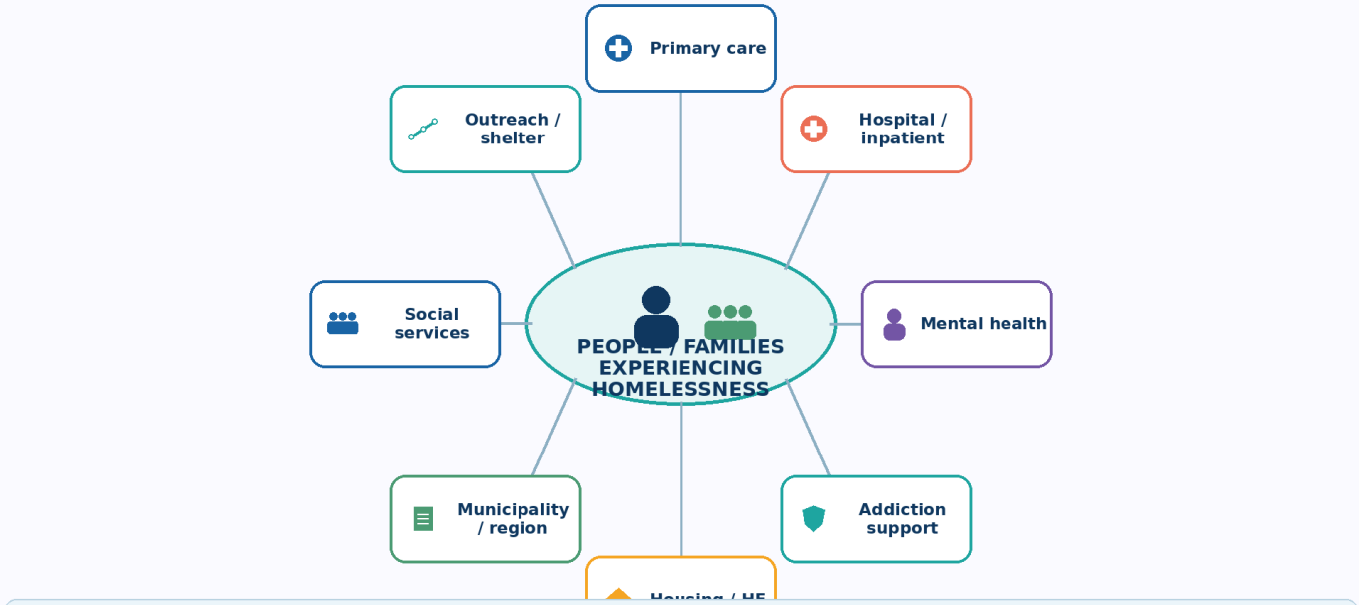
USE PRINCIPLES

- Adapt to local legislation, professional competencies, governance and capacity.
- Use as a structured conversation, not as a compliance score.
- Record assumptions and revisit them as implementation generates new evidence.
- Keep the four IHSC core principles stable while adapting organisational arrangements.

TOOL 1 — Understand the Local Context

Map the ecosystem before designing the service

LOCAL ECOSYSTEM MAP



STARTING QUESTION | What is happening in our community now? Map who is affected, which services matter, and whether people can actually move between them. A directory of services is not enough.

POPULATION / HOUSING SITUATION	WHAT DO WE KNOW?	HOW VISIBLE TO SERVICES?	MAIN CONTACT POINTS

TOOL 1 — Fragmentation, Assets and the Integration Opportunity

Use this page to identify the spaces between services where referrals, transitions or responsibility break down - and the local assets that can be built upon.

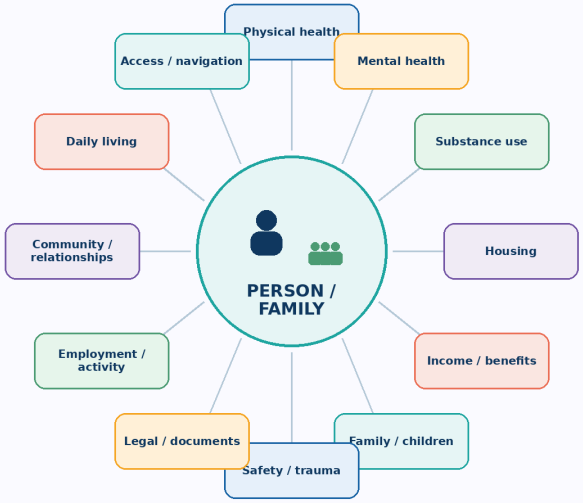
CRITICAL TRANSITION	WHAT SHOULD HAPPEN?	WHAT HAPPENS IN PRACTICE?	MAIN BARRIER / BREAKPOINT	EXISTING ASSET / PARTNER

INITIAL INTEGRATION OPPORTUNITY	WORKING STATEMENT
Priority population / housing situation	
Principal fragmentation problem	
Critical pathway break(s)	
Assets we can build on	
Initial integration opportunity	
Partners essential from the beginning	

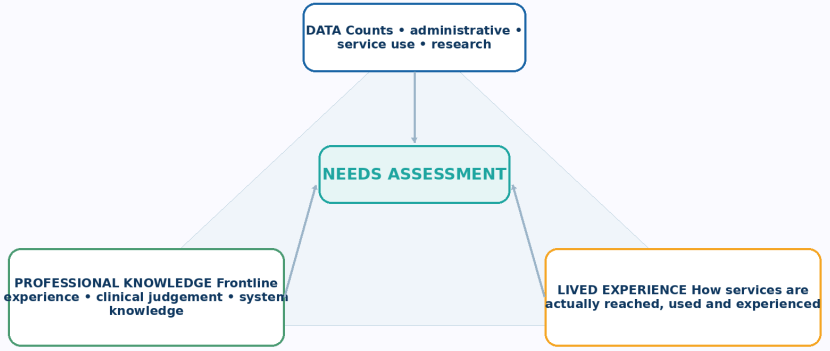
TOOL 2 — Understand the Population and Needs

Combine population evidence with individual and lived-experience perspectives

WHOLE-PERSON / FAMILY NEEDS



EVIDENCE TRIANGLE



TARGET GROUP TEST | Define the population precisely enough to guide service design, but not so narrowly that the definition becomes an unnecessary gatekeeping mechanism.

OPERATIONAL TARGET POPULATION	WORKING DEFINITION
Housing situation / trajectory	
Relevant complexity / needs	
Geographic scope	
Who may be unintentionally excluded?	

TOOL 2 — From Needs Assessment to Design Decisions

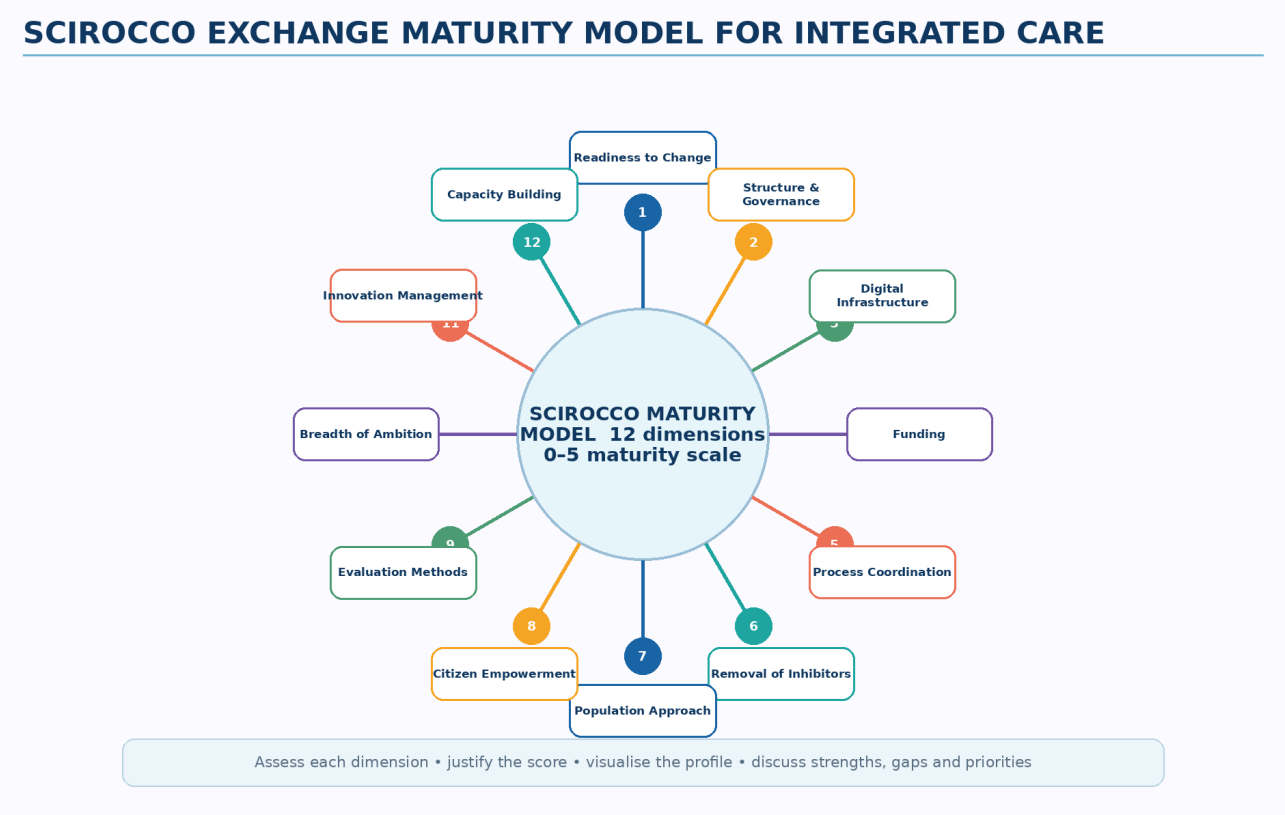
DOMAIN / NEED	EVIDENCE	UNMET OR POORLY MET?	MAIN BARRIER	DESIGN IMPLICATION	PRIORITY

LIVED-EXPERIENCE QUESTIONS | What happens when you need help? Where do you go? What makes care difficult to use? Which services do you avoid and why? What support has actually helped? What matters most to you now?

NEEDS-TO-DESIGN SYNTHESIS	WORKING STATEMENT
Three priority needs the model must respond to	
Three barriers the design must remove or reduce	
Functions that should be available directly or through partners	
Groups / needs still poorly understood	

TOOL 3 — Original SCIROCCO Maturity Model

Use the original SCIROCCO model as a concise self-assessment reference for integrated care.

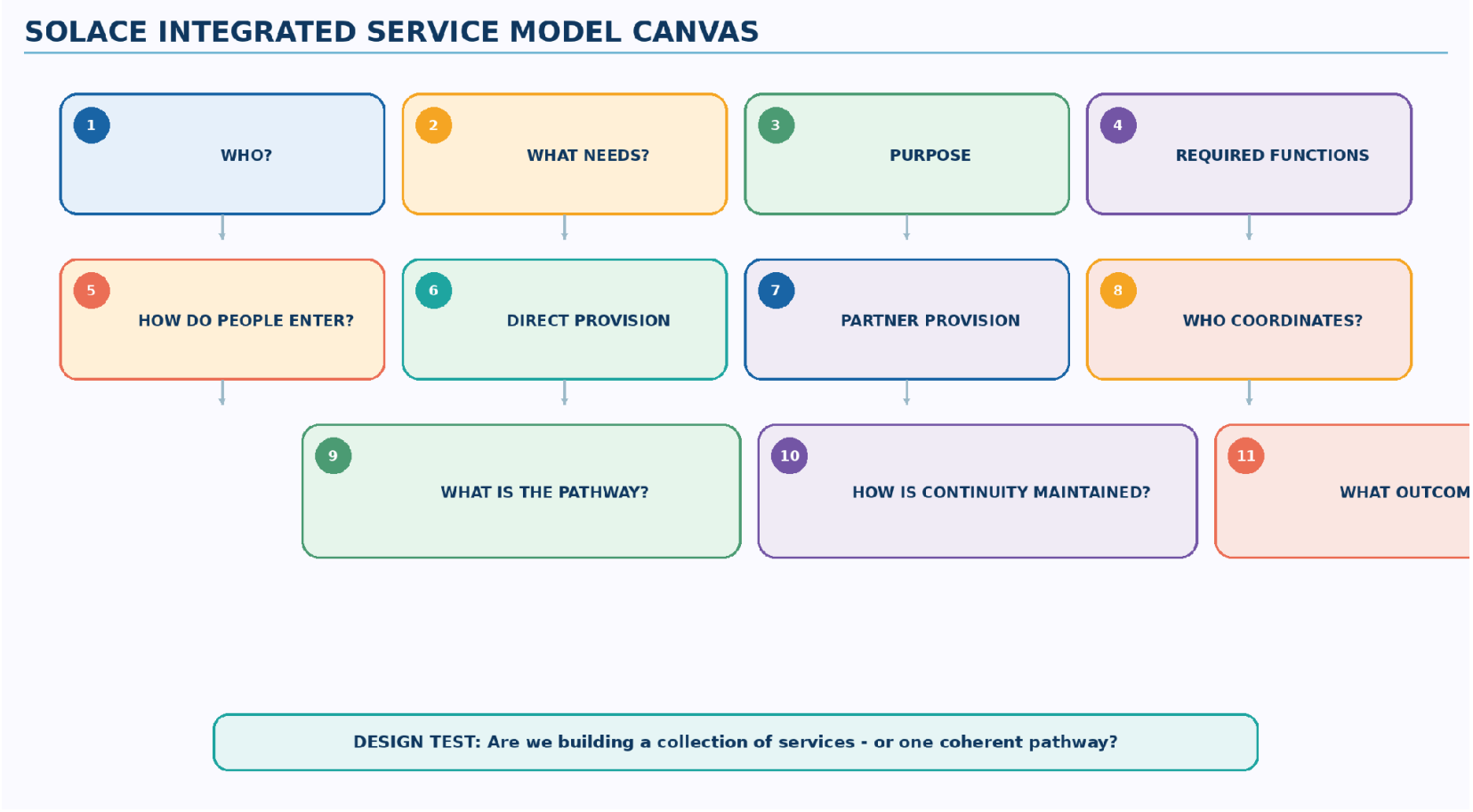


WHAT IT IS	The original SCIROCCO Exchange Maturity Model is a structured framework for reflecting on the maturity and readiness of health and care systems for integrated care.

HOW IT WORKS	It covers 12 dimensions. Each dimension is assessed on a 0–5 maturity scale and accompanied by a short justification. The combined profile can be visualised as a radar / spider diagram.
WHAT IT SUPPORTS	The model helps stakeholders identify relative strengths and gaps, build a shared understanding of readiness, and discuss priorities for improvement, knowledge transfer and scaling.
HOW TO USE IT IN THE PMG	Use SCIROCCO as a diagnostic and developmental reference rather than a pass/fail test. The PMG uses it to support structured reflection on readiness and maturity.
ORIGINAL RESOURCE	**SCIROCCO Exchange — Maturity Model for Integrated Care** https://www.sciroccoexchange.com/maturity-model

TOOL 4 — Design the Integrated Service Model

Translate context, needs and readiness into a coherent model

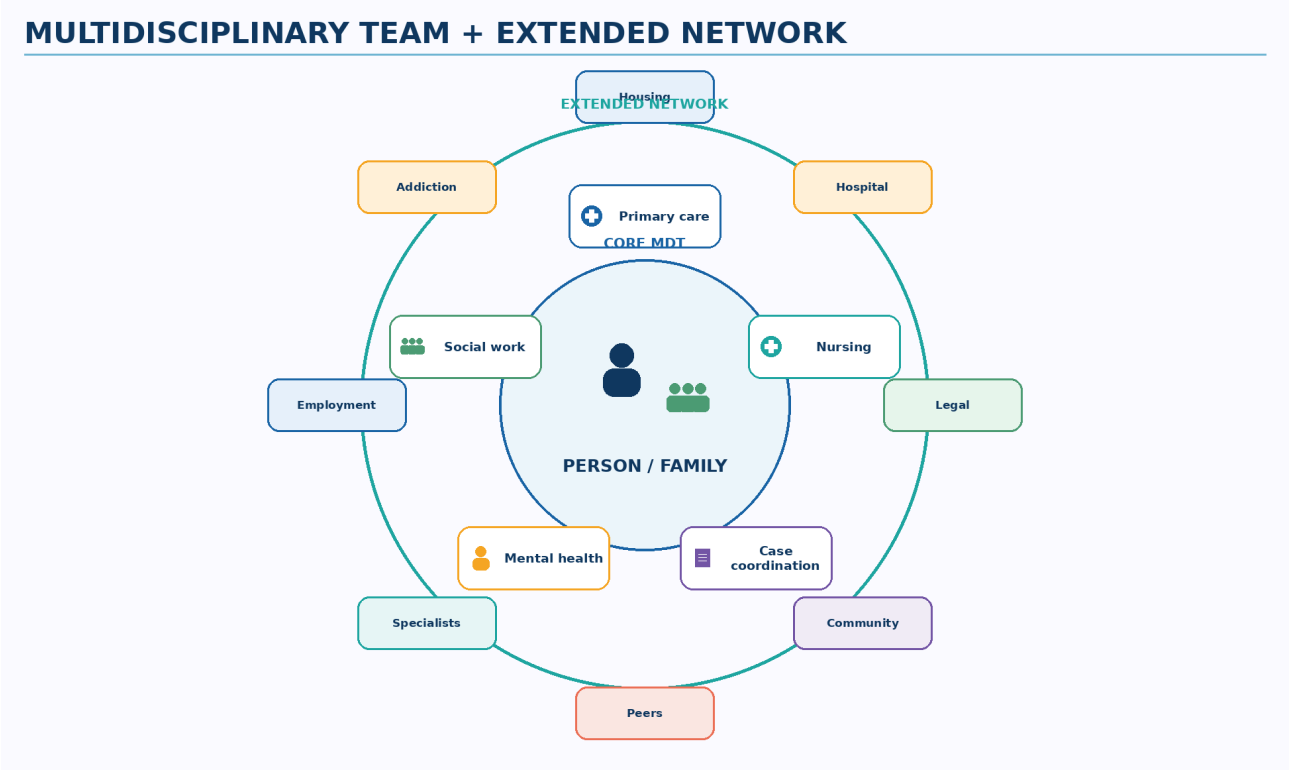


CANVAS ELEMENT	WORKING DECISION
WHO?	

CANVAS ELEMENT	WORKING DECISION
WHAT NEEDS?	
PURPOSE	
REQUIRED FUNCTIONS	
ENTRY POINTS	
DIRECT PROVISION	
PARTNER PROVISION	
COORDINATION FUNCTION	
PATHWAY	
CONTINUITY	
OUTCOMES	

TOOL 5 — Build the Multidisciplinary Team

Start with needs and functions, then connect the expertise required



NEED / FUNCTION	EXPERTISE REQUIRED	CORE MDT	EXTENDED NETWORK	CURRENT GAP

NEED / FUNCTION	EXPERTISE REQUIRED	CORE MDT	EXTENDED NETWORK	CURRENT GAP

TOOL 5 — Clarify Responsibility

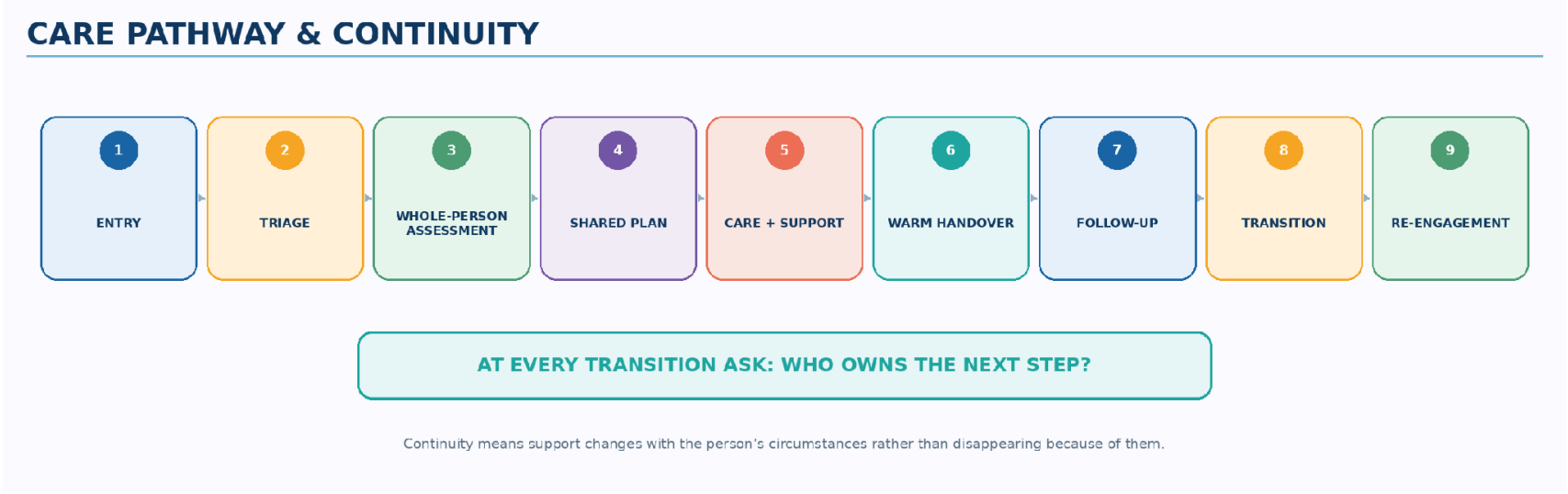
Use RACI where recurrent processes or transitions need explicit ownership

KEY PROCESS / TRANSITION	R — RESPONSIBLE	A — ACCOUNTABLE	C — CONSULTED	I — INFORMED
First contact / entry				
Initial triage				
Whole-person assessment				
Shared care / support plan				
Referral / warm handover				
Hospital admission / discharge				
Housing transition				
Missed contact / re-engagement				
Safeguarding / crisis escalation				
Review / case closure or step-down				

TEAM TEST | For every important transition, somebody should be able to answer: “Who knows what happened next?”

TOOL 6 — Build the Care Pathway

Design the journey from the person's perspective, not the organisation chart



PATHWAY STEP	WHAT SHOULD HAPPEN?	WHO OWNS THE NEXT STEP?	INFORMATION / CONSENT	FOLLOW-UP / TIMEFRAME
Entry				
Triage				
Whole-person assessment				
Shared plan				
Direct care / support				
Referral / warm handover				
Transition				
Follow-up / re-engagement				

TOOL 6 — Breakpoint and Continuity Stress Test

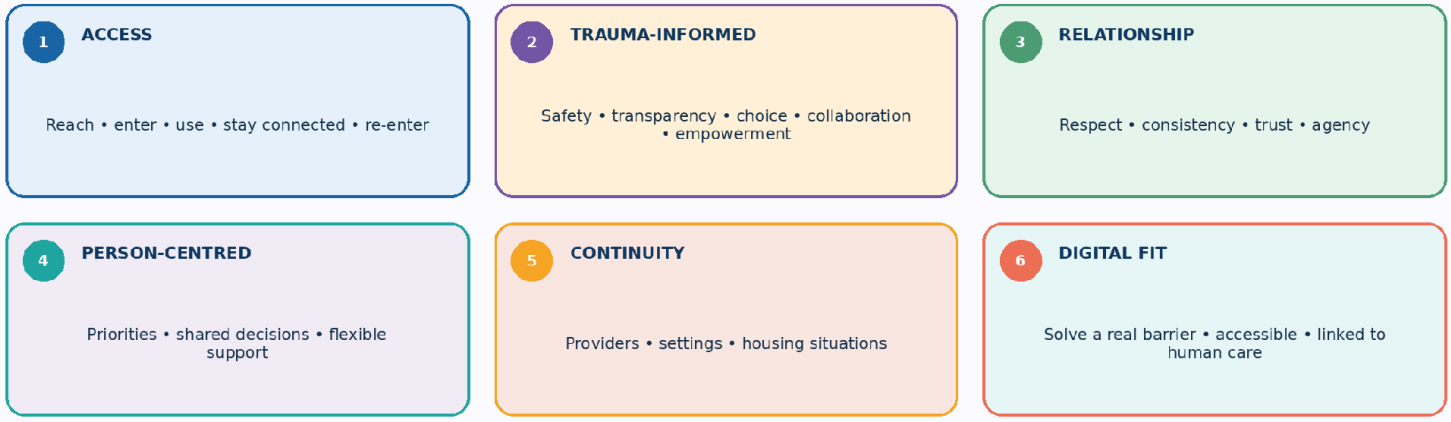
CRITICAL TRANSITION	WHAT SHOULD HAPPEN?	WHAT CAN FAIL?	EARLY WARNING SIGNAL	OWNER / ESCALATION	BACK-UP ROUTE

CONTINUITY TEST	YES / PARTLY / NO	WHAT NEEDS TO CHANGE?
Can people enter through more than one point?		
Are warm handovers available when passive referral is unlikely to work?		
Does somebody follow whether the next step happened?		
Can people re-enter after missed contact or disengagement?		
Does support continue across hospital, shelter, temporary accommodation and housing transitions?		
Does housing change support intensity rather than automatically end support?		

TOOL 7 — Test the Quality of Implementation

Check whether integrated care is experienced as accessible, relational, person-centred and continuous

INTEGRATED CARE QUALITY CARD



Rate each domain: ESTABLISHED | NEEDS STRENGTHENING | MAJOR GAP

QUALITY DOMAIN	ESTABLISHED	NEEDS STRENGTHENING	MAJOR GAP	EVIDENCE / EXAMPLE	NEXT IMPROVEMENT
Access					
Trauma-informed practice					
Relationship / trust					
Person-centred practice					

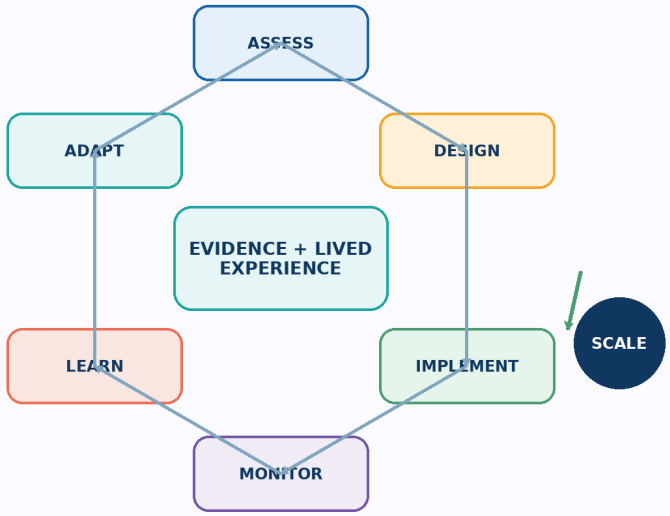
QUALITY DOMAIN	ESTABLISHED	NEEDS STRENGTHENING	MAJOR GAP	EVIDENCE / EXAMPLE	NEXT IMPROVEMENT
Continuity					
Digital fit (if used)					

QUALITY TEST |
Low-barrier care does not mean lower-quality care. Relational quality and professional quality should reinforce each other.

TOOL 8 — Monitor, Learn and Adapt

Turn implementation into a learning system

SOLACE LEARNING LOOP



Scale only when the model is sufficiently mature and evidence supports transfer.

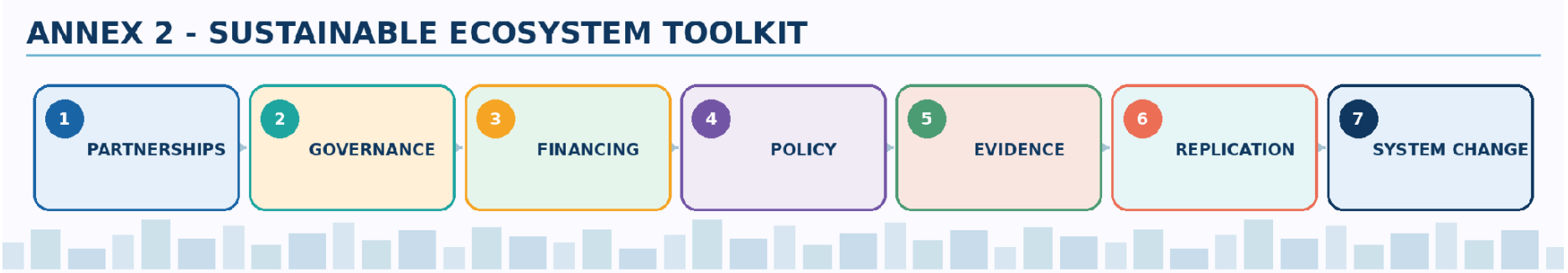
MONITORING DOMAIN	EXAMPLES OF QUESTIONS / INDICATORS	WHAT ARE WE SEEING?
Reach	Who is using the model? Who is missing?	
Access	Which entry points work? Where are delays or barriers?	
Pathway / continuity	Are referrals completed? Where do transitions fail?	
Experience	Do people feel safe, respected and involved?	
Outcomes	Health, housing, safety, engagement, person-defined goals	
Implementation	MDT functioning, partner reliability, digital fit, staff experience	

WHAT ARE WE SEEING?	WHY MAY THIS BE HAPPENING?	WHAT EVIDENCE DO WE HAVE?	WHAT WILL WE CHANGE?	WHO / WHEN?

OUTPUT OF ANNEX 1 | A context-sensitive integrated-care model with defined functions, team responsibilities, pathways, quality expectations and a learning cycle that can be revisited as evidence emerges.

ANNEX 2 - FROM SERVICE TO SUSTAINABLE ECOSYSTEM TOOLKIT

Partnerships • governance • financing • policy • evidence • replication



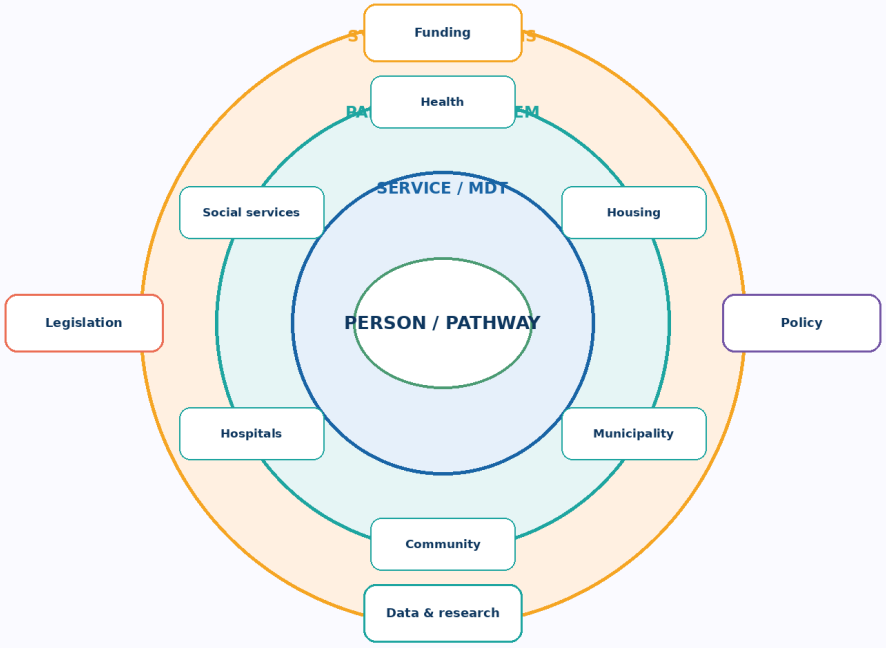
PURPOSE | Translate Level 3 of the PMG into a compact set of strategic tools. Use this toolkit when the service model is operating and the key question becomes whether the pathway can survive, become embedded and influence the wider system.

- Follow the service-user pathway to identify the ecosystem that must support it.
- Move critical cooperation from personal goodwill towards organisational arrangements where needed.
- Finance coordination and continuity, not only visible service activities.
- Use recurring implementation barriers as evidence for organisational, regulatory or policy action.
- Replicate principles and functions; adapt organisational form to the new context.

TOOL 1 — Map the Ecosystem Around the Pathway

Expand the unit of analysis from the service to the conditions that sustain it

FROM SERVICE TO SUSTAINABLE ECOSYSTEM



Sustainability increases when the pathway is supported by structures, not exceptional effort.

LAYER	ACTOR / SYSTEM	ROLE IN THE PATHWAY	DEPENDENCY / RISK	WHAT NEEDS TO BE STRENGTHENED?

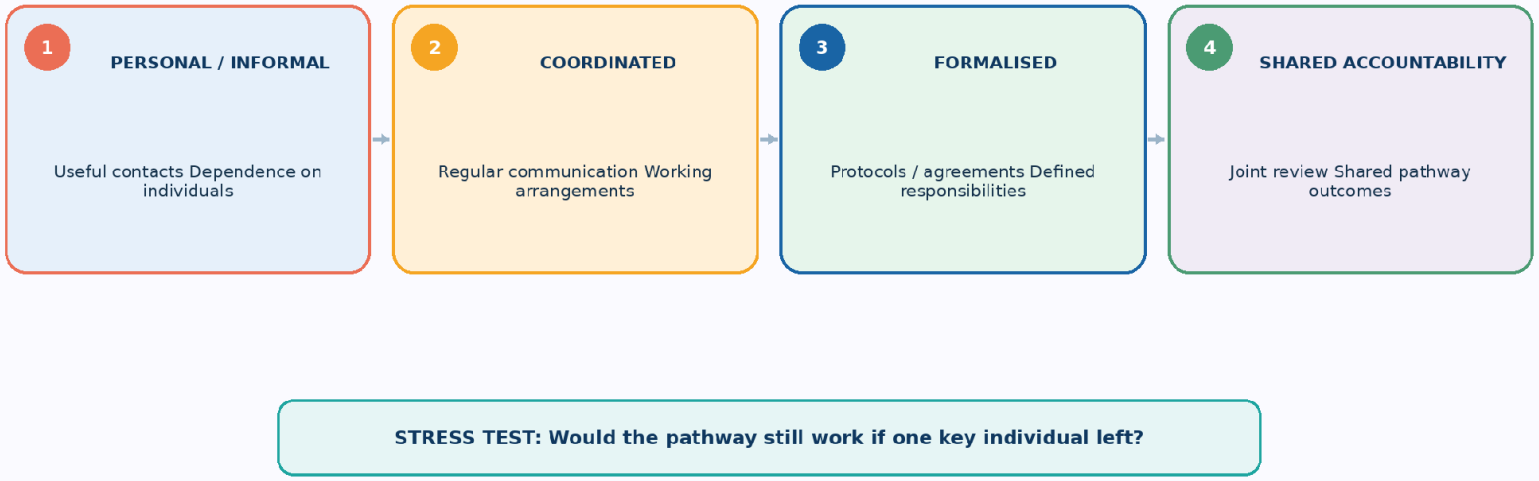
LAYER	ACTOR / SYSTEM	ROLE IN THE PATHWAY	DEPENDENCY / RISK	WHAT NEEDS TO BE STRENGTHENED?

ECOSYSTEM TEST | Which organisations or authorities control critical points in the pathway of the population we support?

TOOL 2 — Strengthen Partnerships and Governance

Move from useful personal contacts towards resilient pathway governance

PARTNERSHIP & GOVERNANCE MATURITY



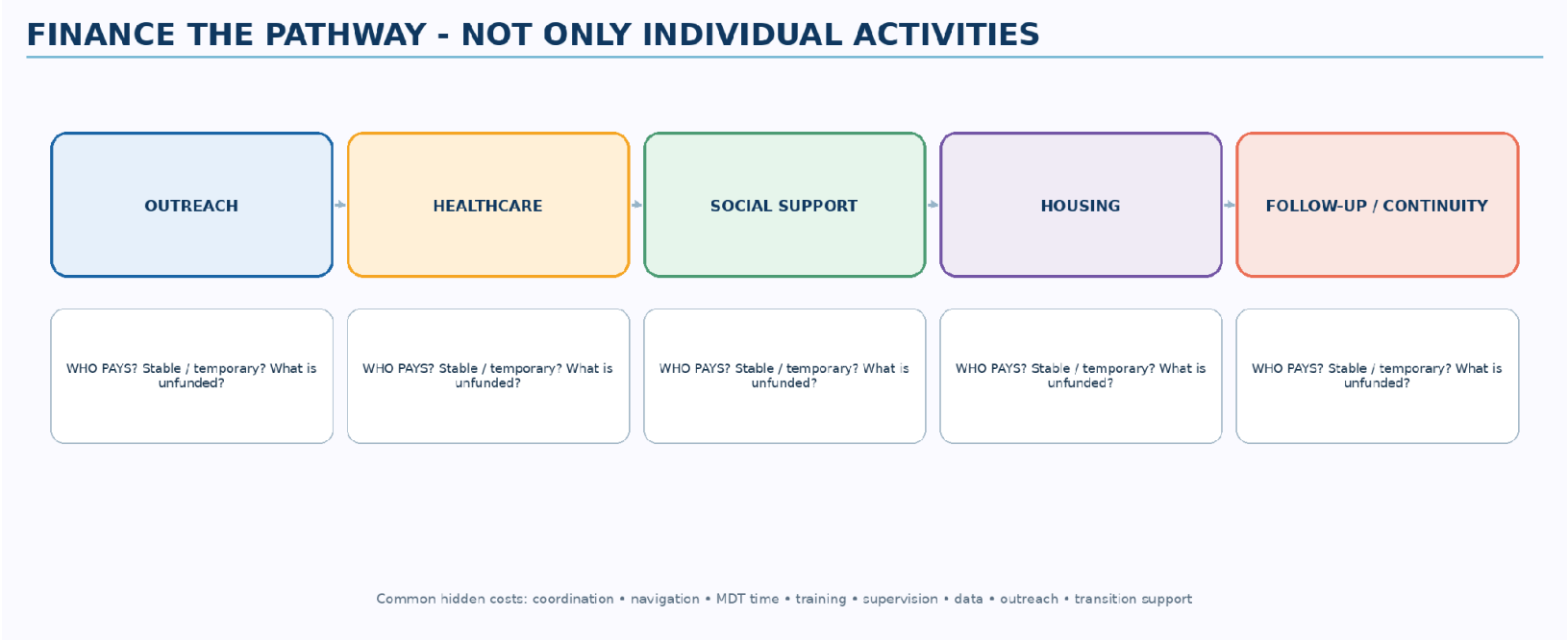
STRESS TEST: Would the pathway still work if one key individual left?

CRITICAL PARTNER / RELATIONSHIP	CURRENT LEVEL 1–4	WHAT WORKS NOW?	WHAT DEPENDS ON INDIVIDUALS?	NEXT FORMALISATION STEP

CRITICAL PARTNER / RELATIONSHIP	CURRENT LEVEL 1–4	WHAT WORKS NOW?	WHAT DEPENDS ON INDIVIDUALS?	NEXT FORMALISATION STEP
GOVERNANCE TEST | Did each organisation perform its task - or did the overall pathway work for the person? Define escalation, information exchange, review and shared accountability where the pathway depends on them.				

TOOL 3 — Finance the Integrated Pathway

Identify the full cost of integration and the functions that conventional funding often misses



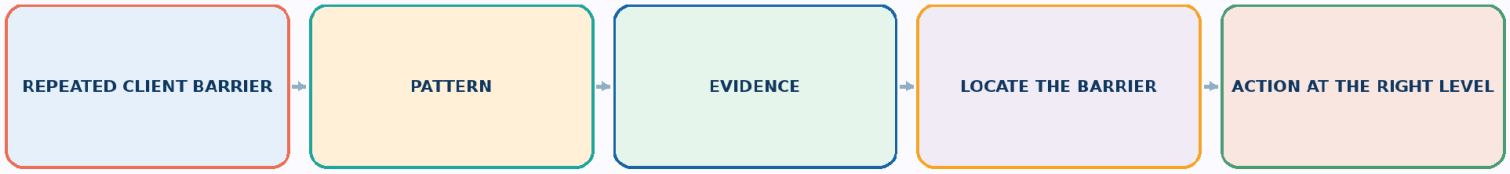
FUNCTION / COMPONENT	CURRENT PAYER / SOURCE	STABLE / TEMPORARY	FULL COST KNOWN?	UNFUNDED INTEGRATION COST?	SUSTAINABILITY ACTION
Outreach					
Healthcare / mental health					
Social / case management					
Housing / housing support					
Coordination / MDT / navigation					
Data / evaluation					
Training / supervision					
Follow-up / continuity					

FUNCTION / COMPONENT	CURRENT PAYER / SOURCE	STABLE / TEMPORARY	FULL COST KNOWN?	UNFUNDED INTEGRATION COST?	SUSTAINABILITY ACTION
FINANCING TEST | Is the pathway sustainable as a whole, even when individual components are paid through different systems? Which essential integration function has no clear long-term payer?					

TOOL 4 — Locate Legal and Policy Barriers

Match the level of the barrier with the level of action

FROM REPEATED BARRIER TO SYSTEM CHANGE



Practice • Organisational • Regulatory • Structural / policy

Do not escalate every problem to policy - but do not repeatedly treat structural barriers as individual failures.

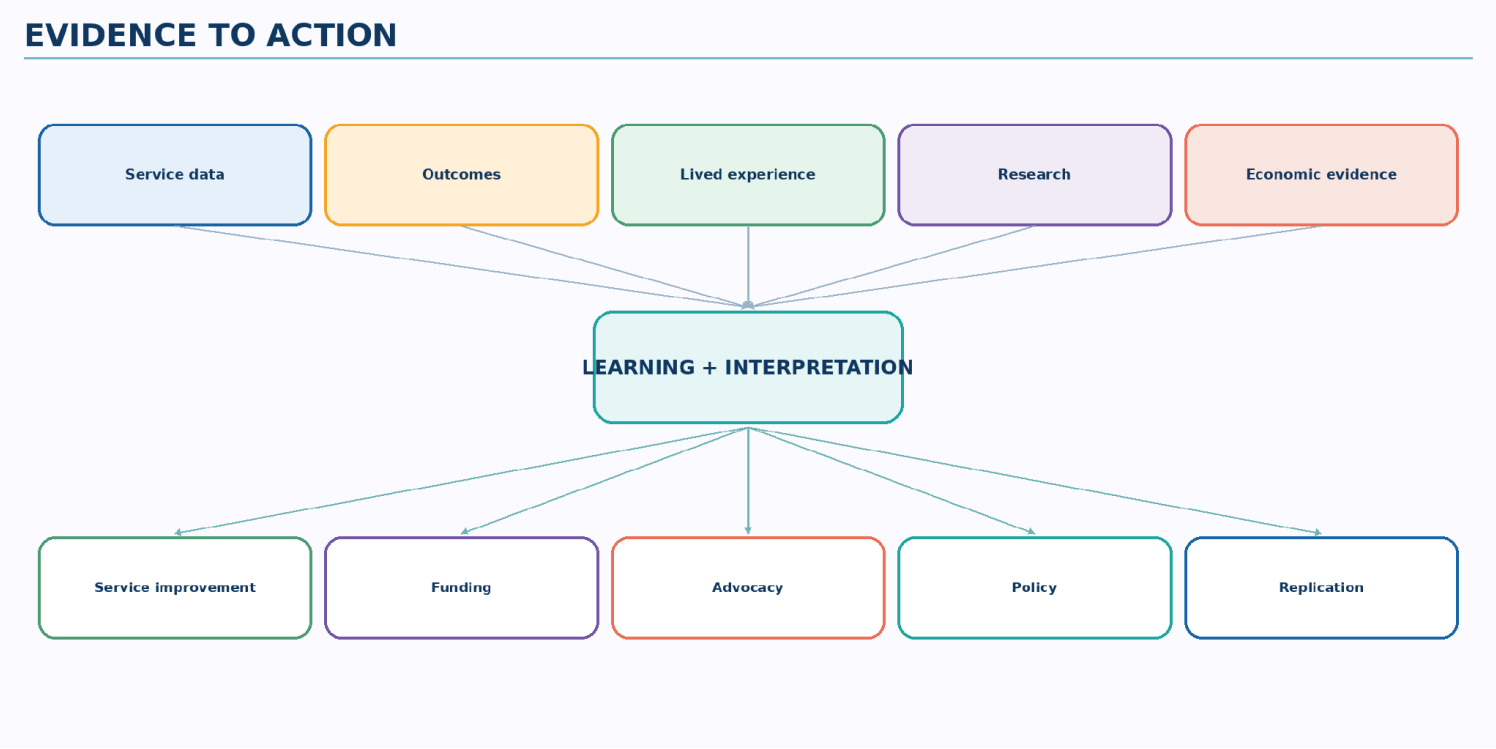
RECURRING BARRIER	LEVEL	EVIDENCE / PATTERN	WHO CAN ACT?	PRACTICAL NEXT STEP	ESCALATE IF…
	Practice				
	Organisational				
	Regulatory / legal interpretation				
	Structural / policy				

SYSTEM RESPONSIBILITY TEST | Do not repeatedly

RECURRING BARRIER	LEVEL	EVIDENCE / PATTERN	WHO CAN ACT?	PRACTICAL NEXT STEP	ESCALATE IF…
manage the consequences of a structural barrier without documenting the pattern and identifying the level at which change is required.					

TOOL 5 — Turn Data and Experience into Evidence for Action

Collect proportionately, interpret jointly, and connect evidence to decisions

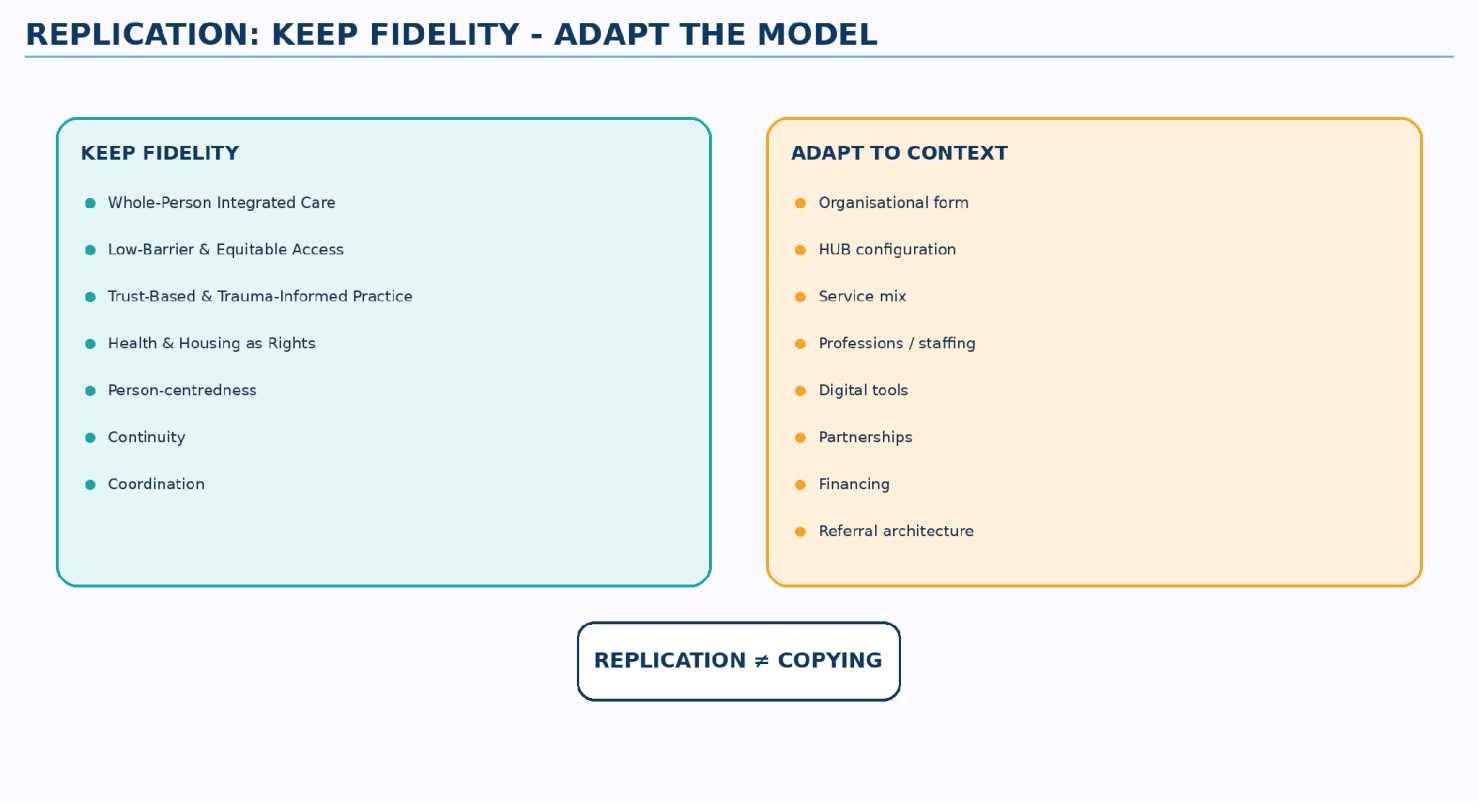


DECISION WE NEED TO INFORM	EVIDENCE NEEDED	DATA SOURCE	LIVED-EXPERIENCE INPUT	WHO WILL USE IT?	WHEN REVIEWED?
Service improvement					
Sustainability / financing					
Partnership / governance					
Policy / advocacy					
Replication / scaling					

DECISION WE NEED TO INFORM	EVIDENCE NEEDED	DATA SOURCE	LIVED-EXPERIENCE INPUT	WHO WILL USE IT?	WHEN REVIEWED?
EVIDENCE TEST | Which information do we need in order to understand and improve the model? Lived experience is evidence when it explains how the pathway is actually experienced and why quantitative patterns occur.					

TOOL 6 — Replicate with Fidelity and Adaptation

Transfer principles, functions, competencies and learning - not one organisational structure



REPLICATION QUESTION	CURRENT ANSWER / EVIDENCE	ACTION BEFORE SCALE OR TRANSFER
Which core principles and functions must remain intact?		
Which organisational arrangements are context-specific?		
Has the new context repeated context, needs and readiness assessment?		

REPLICATION QUESTION	CURRENT ANSWER / EVIDENCE	ACTION BEFORE SCALE OR TRANSFER
Are governance, workforce, data and financing mature enough for expansion?		
What must be standardised as scale increases?		
What evidence supports replication or institutionalisation?		

REPLICATION TEST | Too little adaptation can produce a model that does not fit the local system. Too much adaptation can remove the mechanisms that made the model effective.

Maturity reference: when assessing readiness for scaling, refer to Annex 1, Tool 3 and the original SCIROCCO Exchange Maturity Model: https://www.sciroccoexchange.com/maturity-model

TOOL 7 — Ecosystem Action Plan

Convert ecosystem analysis into a small number of owned, evidence-informed priorities

PRIORITY	CURRENT GAP	REQUIRED CHANGE	WHO NEEDS TO ACT?	EVIDENCE NEEDED	NEXT STEP	TIMEFRAME

ANNEX 2 - SUSTAINABLE ECOSYSTEM TOOLKIT



DIRECTION OF TRAVEL | Local problem → Integrated response → Evidence → Partnership → Institutionalisation → Replication → System change. Different actors influence different levels; identify the organisation's realistic sphere of influence.

ANNEX 2 — Final Ecosystem Review

Can the integrated pathway survive beyond exceptional effort and temporary arrangements?

ECOSYSTEM CONDITION	YES	PARTLY	NO	EVIDENCE / NEXT ACTION
Critical partnerships follow the actual pathway and have clear roles				
Key transitions would survive staff turnover				
Coordination and continuity functions have a viable funding route				
Main legal / policy barriers are identified at the correct level				
Data and lived experience are used for improvement and advocacy				
The model distinguishes fidelity from local adaptation				
Scaling / replication is supported by sufficient organisational maturity				
Successful practices are moving towards routine or institutionalised arrangements				

OUTPUT OF ANNEX 2 | A prioritised ecosystem-development agenda showing which partnerships, governance arrangements, financing mechanisms, evidence and system changes are required to sustain and extend the integrated pathway.

ANNEX 3 - SOLACE-CEE PMG Quick Reference & Visual Guide

SOLACE-CEE PMG Quick Reference & Visual Guide

PMG at a Glance

One methodology, three levels



Understand → Implement → Build the Ecosystem → System Change

Use the PMG as a practical methodology for designing, implementing and strengthening integrated health and social care for people experiencing homelessness.

SOLACE-CEE PMG Quick Reference & Visual Guide

A visual companion to the Project Methodology Guidelines

From understanding homelessness to integrated care, sustainable ecosystems and system change.



The Methodological Cycle

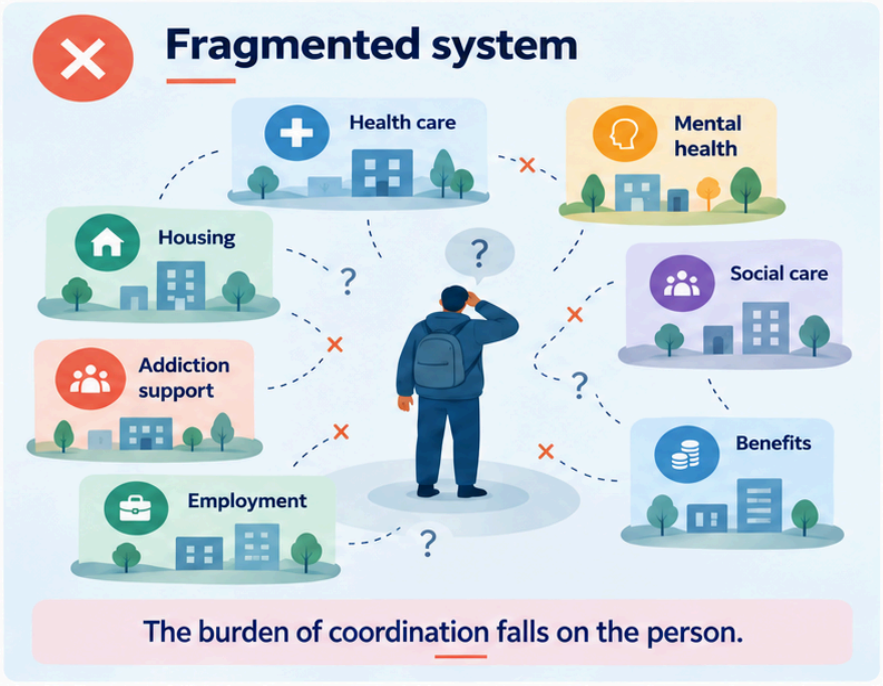
Assess → Design → Implement → Monitor → Learn → Adapt → Scale

The Purpose of This Guide

1. **Understand the foundations of integrated care**
   Gain a shared understanding of homelessness, integrated care and the key concepts, evidence and principles that guide the approach.
2. **Build and improve integrated services**
   Apply practical guidance to design, implement and monitor integrated health and social care services for people experiencing homelessness.
3. **Strengthen ecosystems and support system change**
   Work across sectors to build sustainable ecosystems, increase impact and contribute to long-term system change.

Why Integrated Care?

The problem the PMG is designed to solve





1 The more complex the person's needs, the less the burden of integration should fall on the person.

2 The building is not the model. The pathway is the model.

Four Core Principles

What should remain true in every context

1 Whole-Person Integrated Care

See and respond to interconnected health, housing and social needs.



2 Low-Barrier and Equitable Access

Make care realistically reachable, usable and continuous.



Person-centred integrated care



3 Trust-Based and Trauma-Informed Practice

Build safety, respect, choice, consistency and trust.



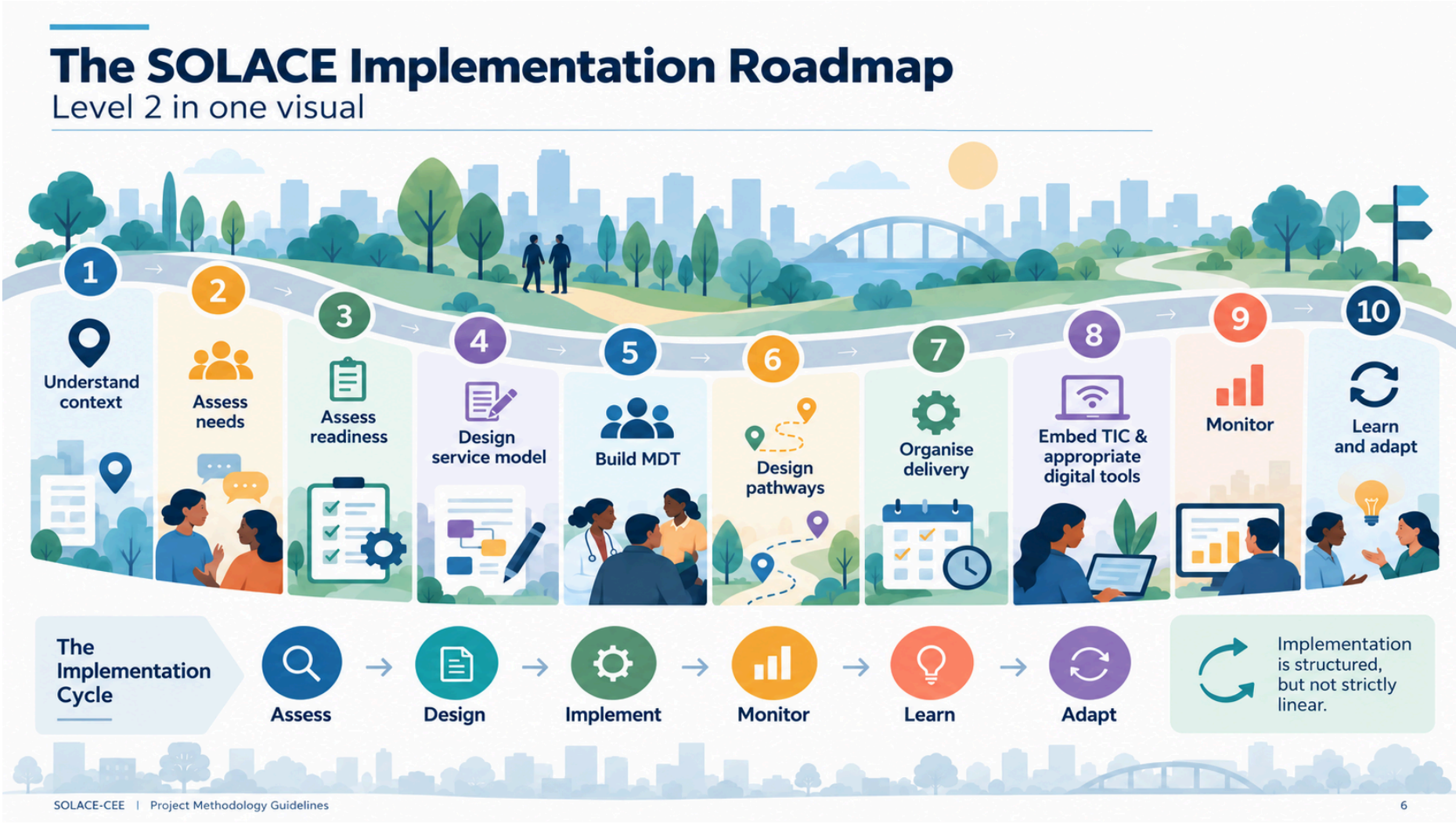
4 Health and Housing as Rights – System Responsibility

Do not locate system failure solely in the individual.



The four principles provide fidelity across different local contexts.


From Core Principles to Practice
How the methodology is operationalised
Turning shared principles into practical action for integrated care and lasting change.
Core principles
Whole-person care
Address the full range of people's health, social and wellbeing needs.
Access
Remove barriers and ensure equitable access to integrated services for all.
Trust & TIC
Build trusting relationships through trauma-informed approaches.
Rights & system responsibility
Uphold human rights and shared responsibility across systems.
Operating principles
Person-centred care
Housing First values
Trauma-Informed Care
Recovery orientation
Harm reduction
Participation
Implementation mechanisms
Outreach
Case management
Multidisciplinary teamwork
Care pathways
Continuity of care
Appropriate digital health
Data-informed learning
Implemented in local context
Implemented in local context
SOLACE-CEE | Project Methodology Guidelines
5


The SOLACE Implementation Roadmap
Level 2 in one visual
1
Understand context
2
Assess needs
3
Assess readiness
4
Design service model
5
Build MDT
6
Design pathways
7
Organise delivery
8
Embed TIC & appropriate digital tools
9
Monitor
10
Learn and adapt
The Implementation Cycle
Assess
Design
Implement
Monitor
Learn
Adapt
Implementation is structured, but not strictly linear.
SOLACE-CEE | Project Methodology Guidelines
6

Whole-Person Integrated Care

What needs to be connected?

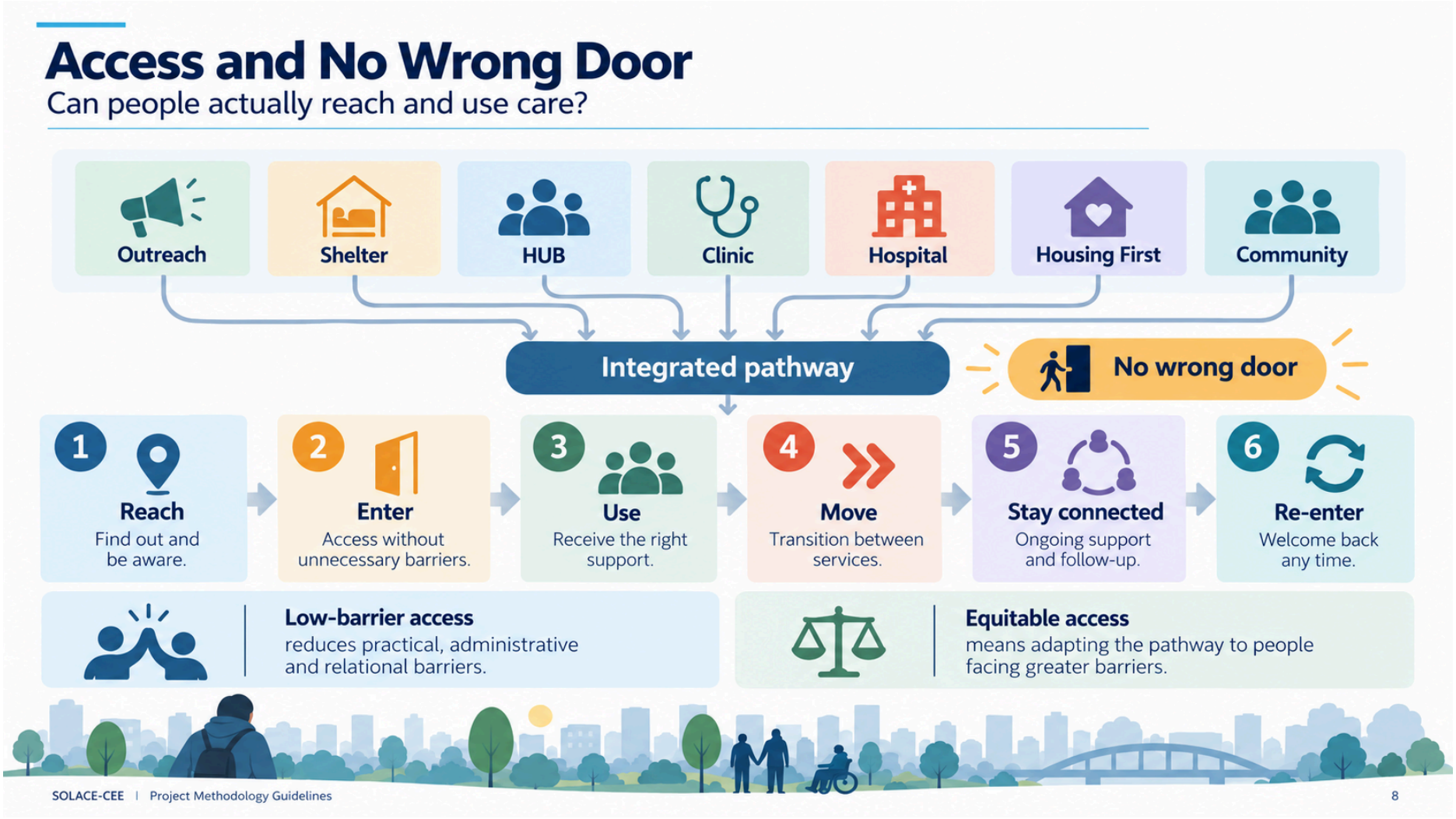
1

Everyone does not need everything. But nothing important should disappear because it falls outside one professional mandate.



2

Integrated care connects functions into one coordinated response.


Access and No Wrong Door
Can people actually reach and use care?
Outreach
Shelter
HUB
Clinic
Hospital
Housing First
Community
Integrated pathway
No wrong door
1
Reach
Find out and be aware.
2
Enter
Access without unnecessary barriers.
3
Use
Receive the right support.
4
Move
Transition between services.
5
Stay connected
Ongoing support and follow-up.
6
Re-enter
Welcome back any time.
Low-barrier access
reduces practical, administrative and relational barriers.
Equitable access
means adapting the pathway to people facing greater barriers.
SOLACE-CEE | Project Methodology Guidelines
8

Integration HUB and Multidisciplinary Team

Gateway, team and wider network

1 Integration HUB

The Integration HUB is the gateway for people experiencing homelessness. It connects individuals to the right services, coordinates support across partners and links to specialist networks when needed.



Direct services

Provide immediate, person-centred support through integrated services at the HUB.





Coordinated partner services

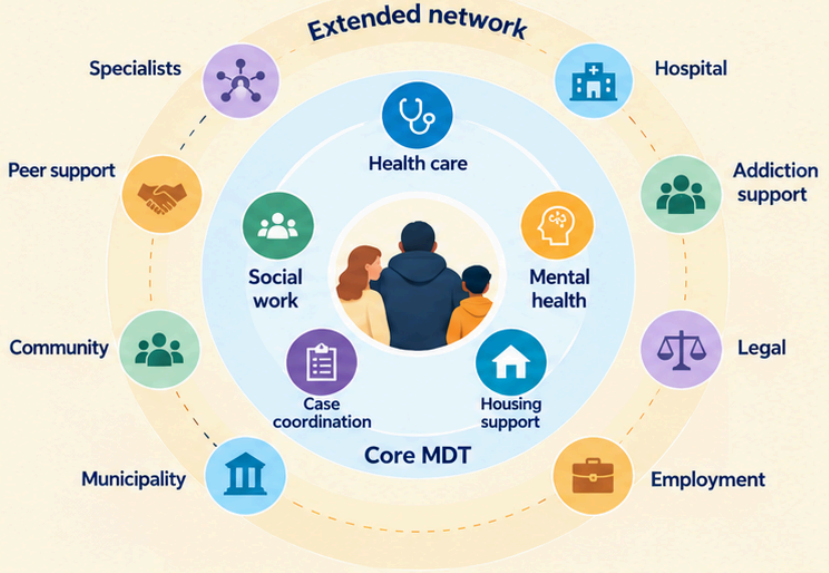
Align and coordinate services across sectors to ensure joined-up, continuous support.

Referral / specialist network

Link to specialist services and external networks for additional support when required.

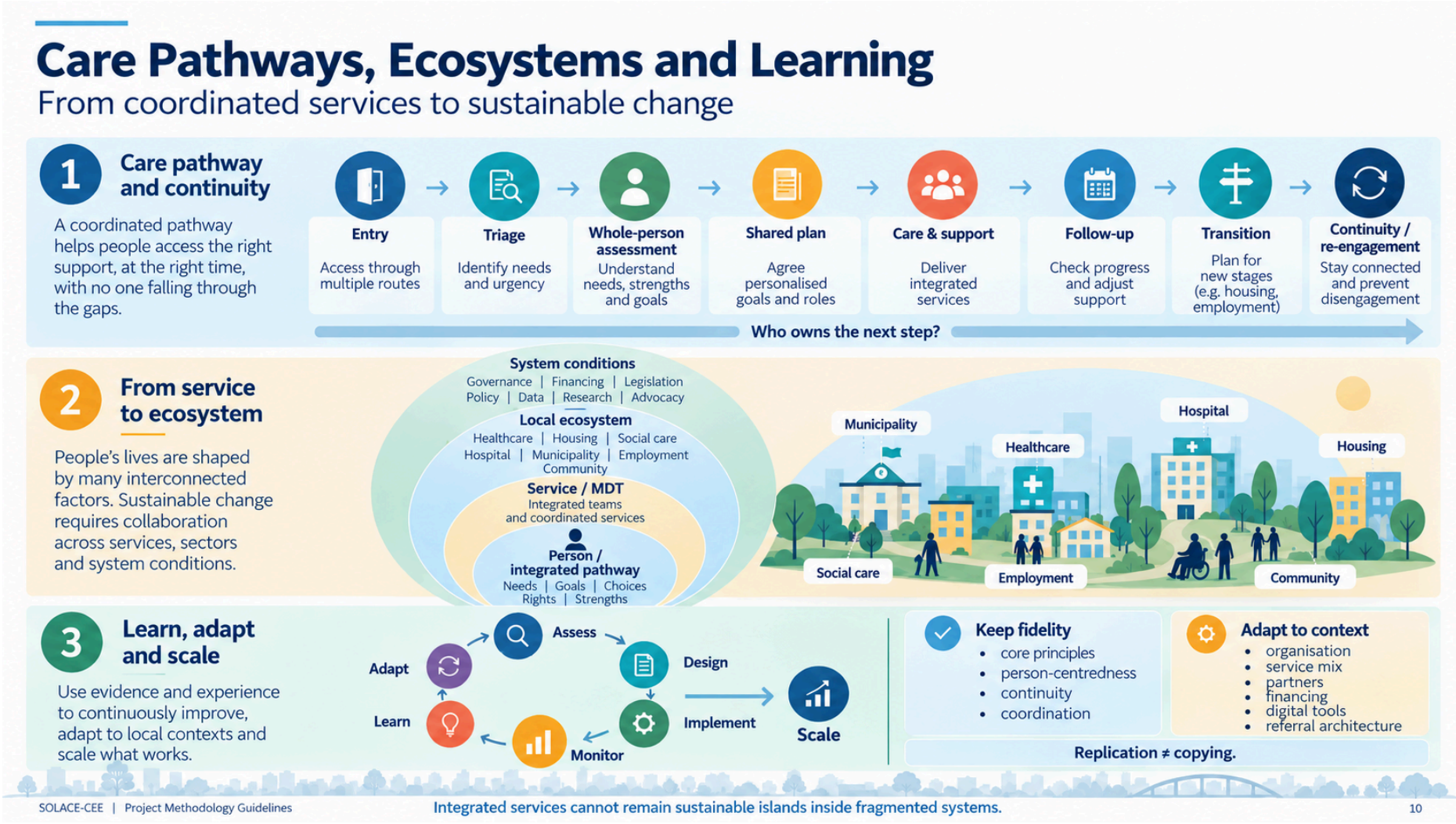
2 Multidisciplinary team

The Multidisciplinary Team (MDT) brings together different professional perspectives around the person or family, with clear roles and strong links to a wider support network.



> **" A room full of professionals is not yet an MDT.**
> Shared understanding + clear roles + follow-up = integrated teamwork."

SOLACE-CEE | Project Methodology Guidelines 9


Care Pathways, Ecosystems and Learning
From coordinated services to sustainable change
1
Care pathway and continuity
A coordinated pathway helps people access the right support, at the right time, with no one falling through the gaps.
Entry
Access through multiple routes
Triage
Identify needs and urgency
Whole-person assessment
Understand needs, strengths and goals
Shared plan
Agree personalised goals and roles
Care & support
Deliver integrated services
Follow-up
Check progress and adjust support
Transition
Plan for new stages (e.g. housing, employment)
Continuity / re-engagement
Stay connected and prevent disengagement
Who owns the next step?
2
From service to ecosystem
People's lives are shaped by many interconnected factors. Sustainable change requires collaboration across services, sectors and system conditions.
System conditions
Governance | Financing | Legislation
Policy | Data | Research | Advocacy
Local ecosystem
Healthcare | Housing | Social care
Hospital | Municipality | Employment
Community
Service / MDT
Integrated teams and coordinated services
Person / integrated pathway
Needs | Goals | Choices
Rights | Strengths
Municipality
Hospital
Healthcare
Housing
Social care
Employment
Community
3
Learn, adapt and scale
Use evidence and experience to continuously improve, adapt to local contexts and scale what works.
Assess
Design
Implement
Monitor
Learn
Adapt
Scale
Keep fidelity
core principles
person-centredness
continuity
coordination
Adapt to context
organisation
service mix
partners
financing
digital tools
referral architecture
Replication ≠ copying.
SOLACE-CEE | Project Methodology Guidelines
Integrated services cannot remain sustainable islands inside fragmented systems.
10

ANNEX 4 - HCSOM Case Study

Simon's Case

Executive Summary

This case study presents the situation of Simon, a man living with severe mental illness, addiction-related problems, and chronic homelessness. The purpose of the case is to demonstrate how street social work, integrated care, and telemedicine can support clients with complex and multiple needs.

Introduction

The aim of this case study is to present the life situation, psychosocial functioning, and helping relationship of a person experiencing homelessness with severe mental health and addiction-related problems, hereafter referred to as Simon. The case is particularly complex because Simon lives simultaneously with psychotic symptoms, catatonic schizophrenia, alcohol and substance dependence, as well as mistrust and difficulties in forming relationships rooted in the intergenerational pattern of homelessness.

This case clearly illustrates the multifaceted challenges faced by people experiencing homelessness living with mental illness, who often struggle to survive on the margins of the support system and in a state of social invisibility. The choice of topic is deliberate: during the training programme, special emphasis was placed on understanding the situation of people living on the streets with mental health problems and the challenges involved in social work with this population.

Although Simon's story represents an individual life course, it also highlights systemic problems. The coexistence of homelessness, mental disorders, and addictions is not uncommon; professionals working in the district and across the country regularly encounter people living in similar or even more severe circumstances. This study was written from the perspective of a street outreach social worker and is based on direct contact with Simon and general field experience. Throughout the analysis, I attempt to distinguish between personally observed, verifiable facts and information based solely on the client's own account, which is indicated accordingly. My goal is to demonstrate how individual, psychological, and social factors intertwine in the life of a person belonging to one of the most vulnerable groups in society.

Target Groups and Needs Assessment

Simon was born in Budapest at the end of the 1980´s into a disorganised and unstable family environment. His mother suffers from a severe mental illness, most likely an

untreated bipolar or psychotic disorder. During several periods of her life she lived on the streets, and she currently resides in the women's homeless shelter under full supervision and medication. Very little information is available about Simon's father; he probably left the family at an early stage and, according to Simon, struggled with alcohol-related problems.

Simon's childhood was profoundly unstable. He was placed in residential care institutions several times and later stayed temporarily with relatives. However, neither setting provided lasting emotional security or consistent care. His educational history was fragmented: he completed primary school but never acquired a vocational qualification. As a young adult he survived through casual work, mainly in construction and warehouse jobs, but psychotic symptoms and increasingly severe alcohol use gradually eliminated his capacity to work.

Simon spent significant periods of his life together with his mother, often in public spaces. His mother's religious worldview strongly influenced him, and Simon himself became deeply committed to Christianity. According to his own account, he believes in God as a saviour and has felt since childhood that he has a special mission; he frequently identifies himself as a messianic figure. Religion serves as a source of support and identity. Even in suffering, he finds meaning and guidance through faith.

Homelessness has been a constant feature of Simon's life. Neither he nor his mother has ever had independent housing. Initially he used homeless shelters, but later chose rough sleeping because, as he put it, he "couldn't tolerate the crowds and noise." His relationship with his mother is highly emotional and dysfunctional; at times characterised by deep love and concern, at other times by intense tension and sadness. According to the social workers supporting his mother, her condition often deteriorates after Simon visits her and she remains anxious and irritable for days afterwards. Their relationship is therefore both a source of attachment and a burden.

Simon has served several prison sentences and has spent a total of seven and a half years in custody. His most recent sentence was two and a half years for assault causing minor bodily harm. According to his own account, the incident occurred during a relationship conflict involving tension with his mother-in-law. He had previously been convicted of theft and disorderly conduct, which he claims were committed "for survival."

At the age of twenty-five Simon became the father of a daughter. Together with his former partner, he arranged an open adoption, and the adoptive family allows supervised contact. During periods of greater stability he attempts to maintain a relationship with his daughter. He frequently speaks about her with affection and sadness, acknowledging that he was unable to provide a safe and stable environment for her.

Simon is currently homeless, although from time to time he finds temporary shelter in a car or with acquaintances. His daily life is organised around survival. His primary goal is

obtaining food, followed by securing alcohol, psychoactive substances, and cigarettes. His physical condition has deteriorated; although his weight is normal, his hygiene is neglected. The absence of regular medical care and supervision has left his general health poor.

Simon's mental condition is severely pathological, and the symptoms of schizophrenia are highly pronounced. Hallucinations are frequent and persistent. He has repeatedly reported that he "speaks with the prime minister about his parliamentary immunity" and that "the voices want to tell him what to do." These auditory hallucinations are generally commanding in nature and often contain aggressive or self-destructive content. His mood swings are extreme; depressive and passive periods alternate with impulsive and agitated phases. Catatonic symptoms such as immobility, rigid posture, and withdrawal from the outside world can frequently be observed. His grasp on reality fluctuates considerably.

Simon's self-image and identity are distorted. He often reacts to the world on a childlike emotional level. Romantic disappointments, friendships, and conflicts are experienced with the emotional maturity of an adolescent. At the same time, if a helper communicates with him in a safe and predictable environment, he is capable of adapting to rules and behaving respectfully. In my experience, Simon is fundamentally kind-hearted and empathetic, especially towards those he perceives as being in even greater need than himself. This helpfulness partly stems from his religious upbringing. The Bible and Christian faith provide him with daily guidance. He regularly reads scripture, turns to God for forgiveness, and, in his own words, tries to live according to the teachings of Jesus.

Suicidal thoughts recur throughout Simon's life and intensify particularly when he feels lonely, hungry, involved in conflict, or worried about his mother's mental condition. On one occasion he expressed a concrete intention to commit suicide and had already begun preparations by hanging a rope from a tree. I personally called an ambulance, and Simon was taken to hospital.

However, he is extremely fearful of hospital treatment because, according to his previous experiences, he was "restrained and heavily sedated," which created profound mistrust. After this particular incident he was discharged the next day without psychological assessment, illustrating structural shortcomings within the healthcare system. Simon has been admitted to hospital on several occasions but has always left within a short period of time, most often against medical advice. In my experience, the healthcare system struggles to respond effectively to homeless patients whose mental illness and addiction make cooperation difficult. As a result, despite his severe condition and obvious need for support, Simon frequently remains without adequate and quality care.

Simon's needs simultaneously encompass housing, mental health care, addiction treatment, physical healthcare, and social relationships; therefore, an integrated approach is essential.

Service Design

The service plan focuses on trust-building, maintaining the helping relationship, preventing crises, and providing low-threshold support.

Pathways and Continuity of Care

Simon is fundamentally distrustful of institutional systems. Previous negative experiences, particularly the humiliating situations he experienced during hospital treatment, have reinforced his fear of and mistrust toward both psychiatric and healthcare institutions. He consistently refuses medication, medical examinations, and hospital admission, as he puts it: “I don’t want them to tie me down,” and “they don’t give me enough food.”

In contrast, he is capable of developing a relatively cooperative relationship with professionals within the social care system, especially street social workers, provided that trust is built gradually and empathetically. In my experience, personal relationships represent Simon’s primary source of security. If the helper is consistently present, communicates respectfully while maintaining boundaries, Simon is capable of trust and cooperation. On numerous occasions he has accepted food, opportunities for personal hygiene, or assistance in resolving sleeping arrangements and administrative matters. In day-to-day contact, food and food distribution constitute the most important motivational tools and the most effective way of engaging with him. Although Simon is capable of independently accessing available social services, he often requires reassurance, encouragement, and joint planning regarding how to make use of them.

Simon is generally respectful toward helpers regardless of gender. With female helpers he often develops relationships resembling maternal bonds and tends to trust them more, especially when sharing emotional difficulties. With male helpers he usually forms fraternal or companion-like relationships, often based on shared experiences such as imprisonment or street life. His aggressive behaviour toward male authority figures such as police officers, security guards, and paramedics is primarily driven by fear. In these situations Simon often reports that “the voices want to protect him from bad people,” and he feels unable to resist these internal impulses. Behind the apparent aggression, however, there is always a childlike fear of abandonment and exclusion.

Simon’s case clearly demonstrates that for homeless individuals living with severe mental disorders, the helping relationship is not merely a service provision but a vital emotional attachment. In Simon’s case, the development and maintenance of trust constitute the most important stabilising factor and provide the foundation for future interventions and development.

Service Provision – Telemedicine and telepsychiatry

An important component of the helping process was the telemedicine service operated by the South Buda Social Centre. Because of Simon's previous negative healthcare experiences, he found it difficult to accept face-to-face medical consultations.

Within this service, a social worker acted as a mediator, connecting the client with a physician through an online visit. The physician was not physically present at the institution; the consultation was conducted remotely.

Telemedicine enabled Simon to discuss his health concerns in a safe and familiar environment. This significantly reduced his anxiety and facilitated his engagement with healthcare services and the wider care system.

Coordination and Integration Mechanisms

From a diagnostic perspective, Simon suffers from chronic catatonic schizophrenia accompanied by alcohol and substance use disorders. His psychotic symptoms (hallucinations and delusions) and addictive behaviours reinforce one another: psychoactive substances temporarily reduce anxiety, but in the long term worsen psychiatric symptoms, increasing disorganised behaviour and social isolation. Physically, he is relatively stable; however, sleep deprivation and neglected hygiene further weaken his mental resilience. Due to the chronic nature of his condition, Simon regularly rejects psychiatric treatment, meaning that cooperation can only be developed gradually and on the basis of trust.

From a psychosocial perspective, Simon's personality development was profoundly shaped by early attachment deficits and emotional neglect. His mother's mental illness and the absence of an environment conducive to healthy development prevented the formation of secure attachment patterns. As an adult, he simultaneously seeks safety and fears vulnerability, resulting in ambivalent relationships with others, including helpers. His religious faith serves a dual function: on the one hand it provides meaning, structure, and emotional support; on the other hand, it often becomes incorporated into his psychotic delusions. Nevertheless, faith represents a potential resource within the helping relationship because it provides a framework through which he interprets his experiences.

From a social perspective, Simon experiences chronic homelessness and deep mistrust toward society and institutions. At the same time, it is evident that he is capable of forming trusting relationships with empathetic and consistent helpers, which improves both his stability and willingness to cooperate. Social isolation, rejection, and stigma have become deeply embedded within his identity, creating substantial barriers to

reintegration. The family history also reflects intergenerational trauma: his mother's mental illness, addiction, and homelessness have transmitted patterns of vulnerability that reappear in Simon's own life.

From a systems perspective, the case highlights structural shortcomings within the Hungarian psychiatric and social care systems. The current system primarily responds to acute crises while lacking long-term, continuous support and effective inter-agency cooperation. Due to his limited cooperation, Simon frequently "falls through the cracks" of the system, resulting in fragmented and episodic care. The complex needs of clients like Simon—spanning psychiatric, addiction-related, and social dimensions—are difficult to address within the existing service structure.

Although Simon's condition is chronic, it is not hopeless. In my experience, periods in which he receives safe, accepting, and supportive human relationships are associated with greater stability and increased willingness to cooperate. This demonstrates that relationship maintenance, empathetic presence, and predictability are among the most important therapeutic factors for clients of this type. For Simon, survival is not merely a physical process but also a deeply psychological one. The helper's role is to support this process through regular contact, structured daily routines, and the creation of a sense of security while respecting the client's autonomy and human dignity.

Monitoring and Evaluation

The most significant outcome of the helping process has been the maintenance of contact, periodic improvements in cooperation, and the acceptance of certain services. Simon's acceptance of telemedicine represents a particularly important achievement.

Recommended Interventions

The greatest challenge in Simon's case is building trust and ensuring access to systemic care, as he consistently rejects medication, psychiatric interventions, and hospital treatment. In this context, rather than relying on traditional therapeutic pathways, a low-threshold and relationship-centred approach is justified, focusing on survival, crisis prevention, and the fulfilment of everyday needs. The primary goal is to establish basic safety through access to food, fluids, hygiene facilities, and a safe place to sleep, while enabling the social worker to address Simon's delusions empathetically and without confrontation.

To maintain the relationship and continue building trust, communication should remain non-directive, consistent, and patient. Small gradual steps—such as cooperation in meeting daily needs, food distribution, or facilitating access to hygiene services—not only

address physical needs but also strengthen psychological security. Through motivational work that respects the client's autonomy, therapeutic directions can gradually be introduced, such as meeting with a psychiatrist at a pace determined entirely by Simon himself. Psychoeducation delivered in a simple and understandable way may increase insight into his illness and improve self-awareness, thereby contributing to crisis prevention in the longer term. Harm reduction represents a realistic goal in addressing substance and alcohol use; rather than insisting on complete abstinence, the focus should be on minimising risks and maintaining safety. Motivational interviewing techniques can be used to enhance cooperation by building on Simon's own motivations. At the same time, clear crisis protocols must be in place: in situations involving suicidal risk or severe psychotic deterioration, the helper has a legal and ethical duty to contact emergency services, even against the client's wishes.

For long-term stabilisation, the involvement of community psychiatric services is essential. Ideally, a multidisciplinary team would work with Simon directly in his living environment, including a psychiatrist, addiction specialist, social worker, and psychologist. The goal is not necessarily complete recovery but rather stabilisation, extending periods between crises, and ensuring a minimum quality of life. In the long term, supported housing or a rehabilitation facility would represent the most appropriate pathway, provided that Simon's level of trust makes such a transition possible. Following inpatient treatment and medication stabilisation, the psychiatric unit of the Intaház Home in the Balaton Highlands could offer an especially suitable next step. Its structured, safe, and professionally supported environment would provide opportunities for psychological stabilisation, the initiation of rehabilitation, and the gradual preparation of social reintegration.

Conclusion

Simon's story illustrates the human suffering that unfolds at the intersection of mental illness, addiction, and homelessness. It demonstrates that the current support system is often inaccessible to people living with severe psychiatric disorders or fails to provide them with a sufficient sense of safety. At the same time, regular personal relationships based on trust can preserve hope and a minimum quality of life even under the most difficult circumstances.

Simon is not merely "a homeless man with mental illness" but a person who has lived with rejection since childhood and whose defensive posture toward the world takes the form of appearing frightening and uncontrollable. Yet when someone listens to him without judgement and remains present in a firm but empathetic manner, signs of cooperation emerge, along with the possibility of a different future.

His life exemplifies the complex realities faced by multiply disadvantaged homeless men living with mental illness in Hungary. Psychiatric disorders, alcohol and substance

dependence, intergenerational homelessness, and a history of imprisonment interact cumulatively, dramatically reducing opportunities to escape marginalisation.

At the same time, Simon possesses important personal strengths. He is deeply religious, empathetic, and willing to help others. When communicated with in a safe and structured environment, he is capable of accepting and following rules. His condition is severe but not hopeless. Experience shows that safe, empathetic, and consistent helping relationships can facilitate partial stabilisation and cooperation. The most important helping factors in Simon's case are trust-building, predictable presence, psychoeducation, and the involvement of a structured support network.

The case highlights the fact that the Hungarian care system often struggles to respond effectively to individuals who do not voluntarily cooperate despite clearly requiring ongoing professional and medical support. Without the integration of community psychiatry, low-threshold services, and outreach social work, cases such as Simon's can easily end in tragedy. Simon's story reflects both personal suffering and collective social responsibility: on an individual level, empathy and patience remain the most effective tools; on a systemic level, closer cooperation between social and healthcare institutions is required to ensure that people like Simon do not remain without support.

All cases are anonymised. Names and identifying details have been changed.

ANNEX 5 - NMP Case Study

The rise of Piotr's psychological self-awareness as a base for good decisions on service use

Housing First Poland Foundation
Warsaw, Poland
Target group: adults with history of chronic homelessness; struggling with mental and physical health conditions; currently housed, but with complex support needs; often with previous experience with institutional care or shelters.

1. Client Background

Piotr is a **49-year-old man** currently living with his dog in a transitional training apartment in Warsaw, Poland. He is **single**, has **no family of his own**, and is **no longer in contact with any relatives**. His **parents died** when he was a child, and he and his sister were raised by their grandparents, who subjected them to both **physical and emotional abuse**. After several years, the siblings were placed in **foster care**, and Piotr remained in institutional care until the age of 18.

After being forced to leave foster care due to reaching the age of 18, Piotr spent **15 years experiencing homelessness**. At times, he managed to find temporary accommodation or rent rooms, and he occasionally took on various jobs. However, most of his earnings were lost to **gambling addiction**, which repeatedly left him unable to pay rent and forced him back onto the streets. During this period, he also lost contact with his sister. He does not know how to reconnect with her and believes she may now be living in another part of Poland.

The **traumatic experiences** Piotr endured throughout his childhood - both in his grandparents' home and later in institutional care - combined with years of homelessness and instability, deeply affected his ability to trust others and build healthy relationships. Over time, he became increasingly withdrawn and **isolated**, preferring to live alone and **avoiding social contact whenever possible**. Today, he has **only one close friend**.

For the past several years, Piotr's **dog** has been his main source of emotional support and companionship. He is deeply attached to the animal, although caring for the dog has at times made it more difficult to access emergency shelters or temporary accommodation, as many facilities do not allow pets.

While struggling with homelessness, Piotr sought help from a local organisation supporting people in crisis. A few years later, the same organisation referred him to the Ambivalence Programme of Housing First Poland Foundation, where he is currently using the support aimed at helping him rebuild stability and independence.

2. Health, Social and Housing Needs

Before joining the programme, Piotr had a range of **untreated physical and mental health difficulties** that had never been properly diagnosed nor addressed. For many years, he had experienced symptoms consistent with **depression**, including persistent low mood, low

motivation, low self-esteem, feelings of hopelessness, and, at times, **suicidal thoughts**. Piotr expressed a clear **need for both psychological and psychiatric support**.
He also struggled with several physical health issues, including **obesity**, ischemic **heart disease**, and asthma. His diet was poor and irregular, contributing to deficiencies in various vitamins and minerals. In addition, he **smoked** approximately one pack of cigarettes per day.
Alongside his health-related difficulties, Piotr also faced a number of unmet housing needs. At the time of referral, he was in an unstable housing situation, temporarily staying with a friend in his apartment and at risk of returning to homelessness. He wanted to apply for municipal housing and had no clear information on how to navigate the application process. He found out that one of the requirements for applying was having a registered address in the town of his current residence as well as not being housed in a regular apartment (which he was staying with a friend). This forced him to consider moving into a homeless shelter which was complicated by the fact that he owned a dog. The majority of shelters did not allow pets, making it difficult to secure a roof over one's head without risking separation from his main source of emotional support.
In the past Piotr experienced being **employed without a contract**. Employers were promising to sign a contract after some time of employment, but each time Piotr was asking for it when the moment came, he was let go sometimes even without payment for the past work. When Piotr joined the Ambivalence Programme, he was unemployed and had no stable source of income. He was surviving on his remaining savings and borrowed money. He wanted assistance applying for financial support from social welfare services and expressed a strong desire to find a registered employment with a contract. He also identified resolving his debts as a future goal, although he did not yet feel ready to address this issue immediately.

3. Key Barriers

Service-related barriers: During the first months of support, one of the main challenges was the lack of a stable and private space where Piotr could meet with his support worker. As he was either temporarily staying with a friend or living in a shelter, meetings often had to take place outdoors, for example in parks, or, during bad weather, in public indoor spaces such as shopping centres. This limited the sense of privacy and safety needed for deeper conversations.
Also in the Ambivalence Programme he was not able to receive housing as the programme has no such resources.
System-level barriers: Piotr as a person previously registered for temporary stay in a satellite town to his current town of residence and a person staying in a regular apartment of his friend (regardless of the lack of stability of this housing situation) was considered by the law as a "non-homeless" with no proven "local connection" which made him not eligible for municipal housing.
Individual barriers: Apart from the assistance received from organisations and institutions, he had virtually no social support network - no close family contact and only one close friend. His childhood trauma, experiences in institutional care, and years of homelessness contributed to a **deep mistrust of people and institutions**. As a result, he became **easily**

discouraged and frustrated when facing setbacks or disappointments from services, at times wanting to withdraw completely from contact and support.

4. Intervention

Type of support provided: Since Piotr decided to participate in the Ambivalence Programme, he has been using regular support from a psychologist in the role of support worker and from time to time the rest of the team. The support included weekly meetings - initially in public spaces as well as ongoing phone/voice contact between meetings. The support worker also accompanied Piotr to appointments and meetings with various institutions whenever he requested assistance.

Since The Ambivalence Programme is not providing apartments to participants, Piotr was informed about housing options in town and referred to another local NGO service provider who ran a traditional shelter and supported apartment programme. He was **admitted to the shelter** and later on **transferred to a transitional training apartment**. He is effectively using the support services provided within this service.

The Ambivalence Programme complements the support by providing **regular psychological consultations**, **psychoeducation** and **emotional support**, particularly during periods of crisis or increased psychological distress. Also the programme provides **financial assistance**, including food vouchers during periods when Piotr had no income, coverage of essential medications and dietary supplements, and funding for a gym membership recommended by his doctor as part of improving his physical health.

How the client was engaged: From the beginning of the programme, Piotr remained in regular contact with his psychologist/support worker and engaged consistently with the support offered. Over time, as his situation stabilised and his functioning improved, he began expressing a **preference for less intensive support and greater independence in making decisions**.

Who was involved: In the centre of the support process wasPiotr the professional relationship carefully built between the psychologist/support worker and Piotr. It was co-shaped by the Ambivalence team through regular team meetings and supervisions dedicated to analysing the case, goals of Piotr and attitude of the support worker. Parallel to this Piotr was using **support of many other professionals and institutions** including: social workers from the local social welfare centre; staff from organisations for the homelessness, particularly the NGO providing shelter and transitional apartments; psychologists and medical professionals within the public healthcare system.

5. Pathway

Starting point: When Piotr first approached the NMP, he was experiencing homelessness and living in unstable temporary arrangements with a friend. He was unemployed and struggling with untreated physical and mental health conditions, including depression, obesity, ischemic heart disease and astma.

Key steps/transitions: The first major milestone was Piotr **engaging with psychological and psychiatric support** and **beginning treatment for depression**.

Second was a difficult but practical decision to abandon renting the room in a regular apartment of a friend and to move into a homeless shelter. This step, although initially considered as a step back, opened the window for applying for municipal housing.
Another significant step was moving into a transitional training apartment, which gave him a sense of stability, privacy, and safety for the first time in many years.
Addressing his physical health also became an important part of the process. Piotr registered with a general practitioner, underwent medical examinations, **received diagnoses related to his physical health**, and **began taking prescribed medication**.
Another particularly important turning point was obtaining a registered employment as a bicycle courier. This represented his first stable source of income in many years and significantly improved his financial situation as well as sense of self-worth and constancy/security of the overall living situation.

Current situation: Piotr currently continues to live with his dog in the transitional apartment. He has submitted an application for social housing and is awaiting a decision on the right to municipal housing. He is **employed full-time as a bicycle courier** and is making gradual efforts to **improve both his mental and physical health**.
Although he does not always take medication consistently, he now knows how to access specialist support when needed and is more willing to seek help. He has **started making healthier dietary choices**, is **attempting to quit smoking**, and **regularly attends the gym** as part of improving his health. He also **completed several months of group therapy for people living with affective disorders**.

6. Outcomes

Piotr's **financial and housing situation has become significantly more stable**.
His psychological self-awarness has risen. His ability to recognize and understand his own thoughts, emotions, beliefs, motivations and behaviors as well as their influence on himself and other people became more aparent.
He has also developed greater awareness of his health difficulties and has started taking active steps to improve his wellbeing and change long-standing harmful habits. His **overall emotional stability have improved noticeably**.
Next week, he **will begin individual psychotherapy** with elements of psychoeducation, which was offered to him by the Ambivalence Programme. The Housing First Poland Foundation thanks to the offer of two volunteer psychotherapists is now providing free therapeutic sessions.
Piotr is currently **awaiting a social housing allocation**. His next goals include receiving dental treatment - he has significant tooth loss, which strongly affects his self-esteem and confidence - and addressing his debts. He has already started **setting aside part of his salary each month for dental care** and recently **took the first practical steps toward resolving his financial liabilities**.

7. What Worked Well

One of the most supportive elements of the intervention was Piotr's move into the transitional apartment operated by the ngo service provider (completely outside of the Ambivalence Programme). Having a stable, private, and safe place to live significantly reduced his stress and created conditions that allowed him to focus on other areas of recovery.
The complementary support provided by training apartment staff, alongside the Ambivalence support worker, also played an important role in strengthening his sense of stability and trust.

8. What Was Challenging

For several months, one of the greatest challenges was Piotr's extremely difficult financial situation, as he had no source of income and relied on savings, borrowed money, and emergency support to survive.
Another ongoing challenge was his deep mistrust of institutions and professionals, rooted in earlier life experiences and repeated disappointments. When faced with bureaucratic obstacles, delays, or situations in which he felt unsupported, Piotr would often become quickly discouraged, frustrated, and inclined to withdraw entirely from contact with services. Building a stable and trusting working relationship therefore required consistency, patience, and long-term engagement.

9. Key Lesson for Practice

For people with long histories of trauma, institutional care, and homelessness, **the quality of the helping relationship may be as important as the practical support provided**. Building trust through consistency, reliability, and a psychologically informed approach enabled Piotr to remain engaged despite repeated setbacks, bureaucratic barriers, and periods of discouragement. Rather than focusing solely on housing or individual services, the intervention worked because it **combined emotional support with practical assistance** and effective coordination between multiple providers.
An additional lesson was recognising that **periods of frustration, withdrawal, or reduced engagement should not automatically be interpreted as a lack of motivation or unwillingness to change**. In Piotr's case, these reactions were often linked to previous experiences of trauma, institutional abuse, and repeated disappointments with services. Responding with patience, maintaining contact without applying pressure, and **validating his reactions** proved more effective than attempting to increase engagement through persuasion. This highlights the importance of trauma-informed practice, where setbacks are understood as a natural part of the recovery process rather than as failure or non-compliance.
Another important lesson is the value of **working at the participant's own pace**. As Piotr's confidence and stability increased, the intensity of support was gradually reduced, allowing him to take greater responsibility for decisions and everyday tasks. Respecting his autonomy while remaining available during periods of crisis strengthened his sense of agency and supported long-term engagement.

10. Intersectional Factors

Gender-specific needs: none.
Family/children: no family/children.
Migration background: n/a.
Mental health: long-term depression with occasional suicidal thoughts.
Substance use: occasional alcohol consumption in the past and smoking for many years.
Disability: none identified.
Violence/trauma: experiencing psychological and physical abuse from his grandparents during his childhood, and later in a children's home and during periods of homelessness.

All cases are anonymised. Names and identifying details have been changed.

ANNEX 6 - HESED Case Study

Vera's Story: Creating Safety Beyond Housing

Organisation: Health and Social Development Foundation – HESED

Country / city

Bulgaria, Sofia

Target group

Families living in informal settlements or inadequate housing.

Living situation

Vera lives in a one-room informal dwelling together with her brother and her two daughters, both in early school age. The dwelling lacks running water, indoor sanitation, and stable electricity, creating unsafe and inadequate living conditions for the family.

The family's housing situation remains highly unstable. Vera currently depends on her brother for shelter, but this arrangement is temporary and insecure. There is an ongoing risk that she and her children may lose their accommodation.

1. Client Background

Age / gender

Female, 27 years old.

Housing history

Vera currently lives with her brother and two daughters in a one-room shack in an informal settlement. Before this, she and the children moved between temporary living arrangements due to lack of stable housing. Housing insecurity has been a constant factor throughout the family's life and continues to affect their wellbeing and stability.

Family situation

Vera is the mother of three daughters from different fathers. She currently raises her two older daughters. Her youngest child is in the care of her father. Vera receives limited support from her brother, who currently shares housing with the family.

Socio-economic situation

Vera is unemployed and financially dependent on family support and social benefits. Throughout adulthood, she has often relied economically on intimate relationships for survival and accommodation.

She is illiterate, has no previous work experience, and no developed work habits. She experiences low self-confidence related to employment and independent functioning, which creates significant barriers to financial independence and long-term stability.

2. Health and Social Needs

Physical health

Vera has significant unmet physical health needs related to limited access to healthcare, long-term poverty, and unstable living conditions. She reports strong pain in the chest, breathing problems and headaches, chronic fatigue and has longstanding untreated dental problems. As many women in her situation, she did not visit a gynaecologist, since she gave birth to her younger child. Since she is not insured, she does not have any access to medical services except emergency care.

Even if health is ensured, the children also have ongoing health-related needs connected to inadequate living conditions, inconsistent nutrition, limited access to preventive healthcare, and difficulties maintaining regular hygiene routines due to the home environment. They did not have regular preventive checks and immunisations.

A serious concern regarding the health of the elder child arose when she was admitted to the emergency room after swallowing a large number of pills, she believed to be bonbons. Following a detailed assessment of the circumstances and of the child's mental condition, it was concluded that the incident was accidental and that there was no evidence of suicidal intent or deliberate self-harm.

The assessment identified a need for regular access to healthcare, improved nutrition, preventive health monitoring, dental care, and support in maintaining basic hygiene routines for both Vera and the children.

Mental health / addiction

There is no evidence of alcohol or substance use.

Vera presents with chronic stress, emotional exhaustion, anxiety, insecurity, and low self-confidence. Her life has been shaped by prolonged instability, poverty, dependency in intimate relationships, and repeated experiences of emotional insecurity.

In addition, the mother has reported physical complaints, including shortness of breath and chest pain. Following medical evaluation, these symptoms were considered psychosomatic in nature rather than related to an underlying physical condition. In view of this, the mother was referred for consultation with a psychiatrist for further assessment and support.

The children have also been significantly affected by chronic housing insecurity, poverty, instability in caregiving relationships, and emotional deprivation.

The assessment identified a need for emotional support for both Vera and the children, strengthening emotional regulation, improved parent-child communication, increased emotional safety within the family, and support in building more stable and secure relationships.

Social needs

The family experiences multiple and interconnected social needs related to housing insecurity, food insecurity, poverty, social isolation, and limited access to resources and services.

A key identified need is support in strengthening Vera's parenting capacity and increasing her confidence in caring for the children independently. This includes building greater structure in everyday life, more predictable routines, and increased confidence in responding to the children's developmental and emotional needs.

The assessment also identified the need to establish basic daily routines connected to hygiene, nutrition, supervision, child safety, and consistent caregiving.

The children need a safe and stable environment that supports emotional wellbeing, regular school participation, peer interaction, developmental stimulation, and a sense of belonging.

Vera also experiences significant social isolation and has limited access to supportive adult relationships and positive parenting models outside the family.

The family has substantial material needs, including consistent access to nutritious food, clothing, shoes, hygiene products, and basic household necessities.

There is a significant risk for separation of the family and the children to be placed in foster care because of the housing situation of the family and the children are monitored by Child Protection Department, and every 6 months they come with report regarding the best interest of the children and the risks for their health and development.

Other relevant factors

The family experiences cumulative vulnerability associated with chronic poverty, inadequate housing, low educational attainment, single parenthood, and social exclusion.

Vera is illiterate, which significantly affects her ability to navigate institutions and access services independently.

Preventing school dropout was identified as a central priority due to the long-term risks for the children's development and family stability, as well as main conditions for the children not to be separated by the mother.

3. Key Barriers

Service-related barriers

Vera faces significant barriers in accessing housing, healthcare, and long-term social support. Temporary accommodation options for families are extremely limited and do not provide stable long-term solutions.

System-level barriers

The most significant barrier remains the lack of accessible long-term housing. Access to municipal housing is extremely limited, with long waiting periods, insufficient housing stock, and complex procedures.

The education system previously failed to support Vera's school participation, contributing to illiteracy and long-term exclusion from employment opportunities.

Individual barriers

Vera faces multiple barriers linked to illiteracy, lack of work experience, financial dependency, low self-confidence, and chronic insecurity.

At the same time, she demonstrates motivation to care for her children and increasing engagement in the support process.

4. Intervention

Type of support provided

The intervention began with intensive efforts to improve the family's housing situation, as housing insecurity remains the most significant challenge affecting the wellbeing and stability of the family.

Support included assistance with applications for municipal social housing and temporary accommodation services for homeless individuals and families. The social worker supported Vera in preparing and submitting documentation, communication with institutions, and administrative procedures. Ongoing advocacy and mediation with relevant services were also provided.

Because stable housing has not yet been achieved, the intervention also focuses on reducing the impact of housing insecurity on everyday family functioning and supporting the family in creating as much predictability, safety, and stability as possible within their current circumstances.

A multidisciplinary support approach was implemented involving two psychologists, social worker, outreach worker, nurse, medical doctors, and educational specialists.

Psychological support is provided both individually and within the family system.

Work with Vera focuses on emotional stabilization, anxiety management, strengthening self-esteem, emotional regulation, building autonomy, and reducing dependency patterns in relationships.

Psychological support for the children focuses on emotional expression, emotional regulation, and strengthening their sense of safety.

Joint sessions with Vera and the children focus on improving communication, strengthening the parent-child relationship, and supporting emotional connection within the family.

A practical component of the work supports Vera in strengthening parenting capacity, child supervision, child safety, and creating a safer and more structured home environment.

A key area of intervention is building stable daily routines, including hygiene, regular tooth brushing, mealtime routines, sleep routines, and caregiving consistency.

Medical support is provided through the hub and external partnerships and includes consultations, preventive healthcare, and dental care for both Vera and the children. This support is closely connected to the work on health prevention, hygiene, and establishing daily routines. The gynecologist provided consultation on women's health issues, family planning and preventing unwanted pregnancies.

The children also receive regular medical consultations and preventive health assessments through the hub. This includes blood tests for the early detection of infections and other health conditions, monitoring of immunization status and administration of missing vaccinations when needed, orthopedic screening for musculoskeletal abnormalities, and ophthalmological examinations. These preventive services aim to identify health concerns at an early stage and reduce the long-term impact of barriers to healthcare access associated with poverty and housing insecurity.

Educational support includes school coordination, support for attendance, learning support, educational materials, and prevention of school dropout.

The children participate in structured group activities at the hub. The younger child regularly attends sensory room activities supporting emotional regulation, sensory development, attention, and the experience of calm and safety.

Vera also participates in playgroup activities together with the children, which support the parent-child relationship, reduce isolation, and create opportunities to observe positive parenting role models and learn through shared experience with other mothers.

The family receives ongoing material support through the food programme, additional food donations, clothing donations, shoes for the children, hygiene products, and other essential items.

As part of the practical support process, the team also assisted Vera in applying for monthly child benefits and one-off financial support related to the children's school attendance. She currently receives monthly child benefits, which represent a small but important predictable source of income for the household.

A key element of the intervention is service navigation and accompaniment. Because Vera is unable to read and write, a HESED team member regularly accompanies her to healthcare appointments, schools, institutions, social services, and administrative procedures.

Due to the intensity of the support needs, Vera and the children attend the hub very frequently and are present almost every day. The hub has become an important point of stability in their everyday life. Supporting the family requires continuous follow-up, flexibility, and coordination from the multidisciplinary team.

Employment and financial counselling are also part of the intervention, with a focus on strengthening Vera's confidence, readiness for employment, and long-term independence.

How the client was engaged

Vera was identified during the project's outreach and needs assessment phase due to severe housing insecurity, poverty, and multiple unmet needs.

Building trust required time, consistency, practical support, and a non-judgmental approach. Over time, Vera became increasingly engaged, more consistent in attending meetings, and more active in seeking support.

Who was involved

The support process involves a multidisciplinary team including a social worker, two psychologists, outreach worker, nurse, medical doctors, and educational specialists.

The work also includes coordination with schools, healthcare providers, dental professionals, social assistance services, child protection services, municipal institutions, and organisations providing food, clothing, and humanitarian support.

5. Pathway

Starting point

Vera initially presented with severe housing insecurity, poverty, emotional exhaustion, social isolation, and limited parenting resources while raising two children in highly unstable living conditions.

Key steps / transitions

The intervention included housing advocacy, psychological support, parenting support, healthcare access, educational support, material assistance, and ongoing work toward greater daily stability and independence.

Current situation

The family remains in a vulnerable situation, particularly regarding housing and finances. At the same time, there is greater emotional stability, stronger engagement with support services, improved routines, and better access to healthcare, education, and basic resources.

6. Outcomes

Short-term

Improved access to food, clothing, hygiene products, healthcare, dental care, educational materials, and social assistance. Stabilisation of the immediate crisis situation and regular engagement with support services.

Medium-term

Improved daily routines and caregiving consistency, increased school attendance, stronger engagement with professionals, and improved emotional regulation and family functioning.

Long-term

Expected outcomes include stronger parental autonomy, continued school participation, and reduced long-term risk of family separation.

7. What Worked Well

The gradual development of trust between Vera, the children, and the multidisciplinary team was one of the strongest elements of the intervention.

The hub became a stable and trusted environment providing safety, predictability, practical support, and emotional support.

The integrated multidisciplinary approach allowed multiple interconnected needs to be addressed simultaneously.

Vera demonstrates visible development in her parenting role, increased consistency in caring for the children, stronger engagement with professionals, and growing emotional awareness.

Based on the ongoing work with the family, the team believes that remaining in the care of their mother continues to be in the best interest of the children.

8. What Was Challenging

The most significant unresolved challenge remains the lack of safe, stable, and adequate housing for the family.

Despite ongoing efforts, no housing placement has been secured. Access to housing remains extremely limited due to long waiting periods, limited housing stock, and complex administrative procedures.

Housing insecurity continues to affect emotional wellbeing, parenting capacity, health, daily routines, and long-term family stability.

Another challenge was the limited possibility to engage Vera's brother more actively in the support process. Although he currently provides shelter, the team was not able to involve him directly in the work as part of the wider family system.

School attendance remains especially important in relation to both child wellbeing and family stability. If the children stop attending school regularly, Vera risks losing access to monthly child benefits, which currently provide one of the family's few predictable sources of income.

Irregular school attendance may also raise additional concerns from child protection services regarding the children's wellbeing and caregiving conditions. In Bulgaria, when serious child protection concerns are identified, the first step is assessment of care options within the extended family. If this is not possible, children may be placed in professional foster care.

Employment also remains a complex area of work due to Vera's lack of skills, experience, low self-confidence, and anxiety related to employment and independent functioning.

The team is also aware of the potential risk that, because the hub provides safety, stability, practical support, and belonging, the family may develop dependency on the service itself. This is addressed consciously through ongoing work focused on autonomy, confidence, and long-term independence.

9. Key Lesson for Practice

This case demonstrates the importance of long-term, integrated, relationship-based support for families experiencing chronic housing insecurity and extreme poverty.

Housing instability affects every aspect of family life, including parenting, health, emotional wellbeing, education, and daily functioning. Effective support therefore requires coordinated work across multiple systems.

The case highlights the importance of combining practical assistance with psychological support, parenting work, healthcare, education, and service navigation.

At the same time, it demonstrates the limits of support interventions when structural housing solutions are unavailable. Even intensive multidisciplinary work cannot fully compensate for the lack of accessible long-term housing.

Meaningful change remains possible when support is consistent, flexible, and built around the everyday realities, needs, and strengths of the family.

All cases are anonymised. Names and identifying details have been changed.

ANNEX 7 - CI Case Study

Silvia's New Beginning - free from fear

1. Client Background

Silvia, a 32-year-old Romanian mother of two, entered Casa Ioana following many years of domestic abuse. Her partner exercised coercive control, restricted her access to finances, and isolated her from close family and friends. The family lived in a rented apartment, in the perpetrator's name. Over time, the abuse progressed from emotional manipulation to frequent physical assaults.

Her children, Maria, aged eight, and Andrei, aged five, witnessed multiple violent incidents.

Neighbours reported a violent episode at the family's home which led to a police intervention. The police gave Silvia inconsistent information about emergency protection orders and available services. With no savings and no safe alternative, she left the family home with the children and stayed with a relative before becoming effectively homeless. DGASPC (the General Directorate of Social Assistance and Child Protection) referred her to Casa Ioana, where she was admitted into our temporary accommodation Centre.

2. Health, Trauma, and Social Needs

Silvia's obvious needs related to untreated dental issues, chronic headaches and neuromuscular pain linked to prolonged stress and past injuries. Psychologically, she exhibited symptoms consistent with complex trauma that included intrusive memories, emotional numbing, guilt, shame, and difficulty concentrating. She spoke of her deep mistrust of institutions due to previous experiences due to dismissive and inconsistent responses from authorities.

The children lacked structured routines, emotional containment, and school reintegration. Both needed monitoring for trauma-related symptoms, including anxiety, behavioural issues, and difficulties with peer relationships.

Silvia also required support navigating the healthcare system, registering with a family doctor, accessing social benefits, and securing childcare to enable participation in training and employment.

3. Key Barriers

System-Level Barriers

Romania's legal framework aligns with the Istanbul Convention, yet implementation remains uneven. National analyses highlight operational gaps, insufficient professional training, and inconsistent monitoring of protection orders. Enforcement of protection orders is inconsistent, and sanctions for breaches are not always applied promptly.

Individual Barriers

Silvia struggled with trauma-related avoidance, low self-esteem, and self-blame. Economic dependency, gaps in employment, and lack of childcare made the labour market

re-entry challenging. Fear of retaliation from the perpetrator and social stigma around leaving the relationship further complicated her decision-making.

4. Intervention and Professional Actions

Casa Ioana's multidisciplinary team conducted a comprehensive risk assessment, identifying any ongoing threats from the perpetrator, emotional instability, and the children's vulnerability. A personalised support plan was developed together with Silvia, incorporating safety planning, legal guidance, and therapeutic interventions.

Silvia received assistance applying for a protection order, with clear explanations of legal processes and was accompanied by her social worker to relevant institutions. A lawyer, working on a pro bono basis helped Silvia in divorce proceedings against the perpetrator.

The psychologist started weekly trauma-informed psychotherapy that focused on stabilising Silvia's emotional issues and on helping to develop her personal resources so that she could become self-dependent. Parenting support sessions helped her understand the impact that domestic violence had on her children, which in turn increased her confidence as a mother.

The children were enrolled in a local school and kindergarten and supported through regular social worker contact with teachers. Silvia participated in soft-skills and employability workshops, covering communication, CV writing, and interview preparation. She also received financial literacy training to rebuild her economic independence. Other workshops included personal hygiene, reproductive health and nutritional advice. A private dental practice provides their service without cost.

5. Pathway and Current Situation

Silvia eventually found work through a small cleaning company run by one of our former clients - a woman who had once been in a very similar situation and whom we supported when she set up her own business. Because of that shared experience, she understood Silvia's needs and was willing to give her a chance. The job gave Silvia steady income and, more importantly, a sense of dignity and routine again.

From the start, we encouraged Silvia to put aside a small part of her salary each month to help her move into her own place and take on rent and living costs independently. She was supported to find an affordable apartment that was safe and close enough to the children's schools.

The children settled well into school and have stability and their own space. Silvia still receives psychosocial support from us when she needs it, enough to keep her grounded and supported. She stays in regular contact with Casa Ioana, often calling just to share how the children are doing or to update us on her progress.

6. Outcomes

Silvia has steady employment with a supportive employer, which gives her both financial stability and because she learned to save a little each month, she's been able to manage

the ongoing costs of her apartment without slipping back into crisis. Living in their own home has given the whole family security that they didn't have before. The children are settled in school, making friends. Their teachers report that they're more confident and more engaged in class.

Silvia still reaches out for psychosocial support when she needs it and knows that she doesn't have to face challenges alone. The family keeps in touch with Casa Ioana and shares small updates about school achievements, work progress, or simply how they're getting on.

Overall, the long-term outcome is a family that has moved from crisis to building a future that is safe and self-sustainable.

7. What Worked Well

The integrated, trauma-informed approach, combining safe temporary accommodation, psychotherapy, social support, and employability services, was hugely effective. Silvia was understanding that a child-centred approach helped stabilise the family, while intensive relational work helped rebuild Silvia's confidence.

8. What Was Challenging

Systemic gaps between law and practice created delays and uncertainty. Limited public resources, particularly affordable housing, childcare, and long-term psychological support, slowed progress. Economic insecurity and emotional uncertainty toward the perpetrator also complicated decision-making.

9. Key Lesson for Practice

Silvia's case demonstrates the added value of integrated NGO-led services. Casa Ioana bridged the gap between legislation and lived experience, turning rights into accessible support. Intensive case management, trauma-informed practice, and strong inter-agency coordination are essential for supporting survivors toward independence and long-term stability.

10. Optional: intersectional factors

Gender-specific needs:
As a woman, Silvia faced gender expectations around caregiving and stigma for leaving the relationship, which often influences institutional responses and family attitudes.

Family / children:
Parenting alone with two young children intensifies economic pressure and can limit availability for work and training without reliable childcare.

Migration background:
Not applicable in this case (Romanian citizen); however, similar families with migration backgrounds may face additional language and documentation barriers.

Mental health:

Trauma-related symptoms significantly affected daily functioning and capacity to engage with services so access to specialised, culturally sensitive mental health support was crucial.

Substance use:
No substance use issues were identified.

Disability:
No physical disability identified; however, the psychological impact of trauma did function as an invisible disability in terms of concentration, energy, and decision-making.

Violence / trauma:
Long-term exposure to physical, emotional, and economic abuse, with children as witnesses, impacted the pace of recovery.

Other:
None.

All cases are anonymised. Names and identifying details have been changed.

ANNEX 8 - VPR Case Study

Viktória's Perseverance

1. Client Background

Viktória is a young woman who had experienced several types of homelessness, from shared living to rough sleeping in Košice, Slovakia. She is 25 years old and a single mother of three children, aged 3, 1 and a half and a few months old newborn. She has no contact with her relatives or fathers of her children. Her mother moved towns recently. Viktória is unemployed with little to no work experience.

Viktória grew up in institutional care. Her mother is a sex worker and Viktória had been taken away from her due to neglect of care at an early age. While she was still a minor, her mother had taken her back from the institution, provided accommodation and engaged her illegally as a sex worker right away. Viktória has suffered sexual abuse under these conditions for many years. Due to her engagement in sex work, she had been exposed to substances and developed an addiction herself. This had been detrimental to her physical and mental health. Her use of substances contributed to marginalizing her, causing problems with socialisation and integration into society.

After her first pregnancy, Viktória strived to create a safer and more stable life for her and her child. When her efforts fell short and her firstborn had been taken away into institutional care, she attempted suicide. When Viktória had her second child she stopped working as a sex worker which caused her to lose accommodation. From that point onward, Viktória and her second child experienced various types of homelessness, like rough sleeping and unstable housing. Upon her third pregnancy, she was noticed and approached by the outreach team of VPR. Outreach social workers recommended and connected her with the family shelter and she was able to be successfully accommodated after giving birth to her third child. Since then, she is taking part in the Housing First program run by VPR and Foundation DEDO and is currently waiting to be housed.

2. Health and Social Needs

Viktória's physical and mental health had been neglected and left unchecked. Due to the poverty and lack of food, Viktória was severely malnourished. Her use of substances led to the deterioration of her teeth. People who were supposed to love, care and protect her abused her, which led to development of severe trust issues, unhealthy dependencies, attachments and trauma. She has not been able to get education and had not attended school, therefore was not properly socialized nor integrated into society, her experiences were limited to marginalizing and exploitative interactions within sex business.

Viktória sought change when she got pregnant with her second child. She escaped sex business and overcame her substance addiction. Her mother promised to help her with the care for the newborn but failed to keep her promise when she moved away. Viktória was on her own. This is the period of time when she was approached by an outreach team who

suggested temporary housing at a family shelter which she went on to utilize after giving birth. The social workers built a relationship with her and were able to gain her trust. She consented to medical attention and pre- and post-natal check-ups from the doctor at one of the integrated HUBs operated by VPR. Despite her rough living conditions during the pregnancy, she gave birth to a healthy baby.

3. Key Barriers

Service-related barriers:

Viktória's financial situation is currently dire. She receives support in material need from the state, around 120 euros, which she in turn spends all on the shelter accommodation, as the monthly payment at shelter is 120 euros. This leaves her with no means to take care of herself and her children. Due to one of her children being in institutional care, Viktória is ineligible to receive child support for the two children currently in her care.

System-level barriers:

Viktória had trouble navigating claims of child support due to her missing ID, so she went years without it. She also has unresolved medical debt causing difficulty in getting medical care.

Individual barriers:

Viktória has to overcome her trauma and past substance dependency. This is a never-ending struggle for her. Because of the substances ruining her teeth, Viktória has avoided communication. Her intellect, ability to navigate formal systems and communication skills are underdeveloped due to the limited access to education, stable social relationships, and safe developmental environments. She benefits from clear, consistent and non-judgemental communication. Another possible barrier connected with substances can occur if Viktória would be prescribed any medication. This can create a triggering situation for her, as it might remind her of being dependent on harmful substances which can be counterproductive and create avoidance of taking prescribed medication.

4. Intervention

Type of support provided:

Accommodation, Housing, physical and mental health care, social care. Viktória also has access to the psychiatrist and psychologist at the integrated HUB, should she choose to visit them. This would be an important step in her recovery, because it has the potential to aid her with creating a healthy/safe attachment with her children, effectively influencing their early childhood development.

How the client was engaged:

Viktória went to get her identifying documents sorted and requested that her missing state support is repaid. She handled this by herself, after getting pointers from the social workers on where to go.

Who was involved:
Social workers, medical professionals and peer community.

5. Pathway

Starting point:
Viktória had her two young children with her on the streets. She came to DORKA shelter with no identifying documents which hindered her ability to receive state support.

Key steps/transitions:
Social workers helped Viktória to recover her ID and aided her in a retrospective claim of state support money. Therefore, Viktória was able to save up some money.

Current situation:
Viktória continues to live in a temporary housing situation at a family shelter. This was a decision made together with the social workers as a preventive measure to reduce the risk of potential removal of her children by child protective services. This is because the shelter seemed a suitable option as a part of the crisis management due to the relatively safe space and the community of social workers, peers and mothers at the shelter who can aid Viktória daily. However, Viktória continues seeking a long-term housing solution.

6. Outcomes

Viktória has already come a long way. She is looking forward to a brighter future. She wants to learn to cook. She is working hard to stabilize her and her children's situation. Meanwhile, the Housing First team works on finding a suitable long-term accommodation for Viktória. This is complicated due to the systemic barriers in Slovakia connected to state support for housing. Her biggest goal remains getting custody of her first child so that her family is back together.

7. What worked well

Viktória experienced benefits from the temporary housing at DORKA, even though it was a crisis response. Some of the positive outcomes were her integration and social inclusion. This boosted her confidence and kept her motivated. Her physical health is being taken care of thanks to the integrated services at the HUB. Should she choose to, she has access to mental health care as well. Viktória is on a path to recovery.

8. What was challenging

One of the challenges Viktória continues to face is judgement from her peers. She is looked down upon because of the type of work she was forced to do in the past. Sex work is stigmatized and a taboo topic.

9. Key Lessons for Practice

Viktória's case, as many others, showcases the need for low-threshold integrated health and social services, and importance of access to housing (in this case the Housing First program for families). It highlights the importance of trauma-informed care, creation of a safe space and building a relationship with a client based on mutual respect and trust.

10. Optional: Intersectional Factors

Gender-specific needs:
As a pregnant woman, Viktória received gender-specific medical care. As a sex worker she experienced sexual exploitation. As a woman she is vulnerable to gender-based violence and discrimination.

Family/children:
Viktória is a single mother to three children, two are in her care, while her first has been taken into institutional care.

Mental health:
Viktória lived through serious trauma and abuse. She has access to psychiatric and psychological care.

Substance use:
History of substance abuse. Currently sober.

Disability:
None, besides trauma.

Violence/trauma:
Years of sexual abuse.

Other:
Cases like Viktória's promote the option to get help, bolsters trust when it comes to our organization, spreads the outreach and builds initiative within peer communities to come to us on their own accord.

All cases are anonymised. Names and identifying details have been changed.

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